

EXAMINING STATE EFFORTS TO IMPROVE
TRANSPARENCY OF HEALTHCARE COSTS FOR
CONSUMERS

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
SECOND SESSION

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EXAMINING STATE EFFORTS TO IMPROVE TRANSPARENCY OF HEALTHCARE COSTS FOR CONSUMERS

TUESDAY, JULY 17, 2018

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322 Rayburn House Office Building, Hon. Gregg Harper (chairman of the subcommittee) presiding.

Members present: Representatives Harper, Griffith, Barton, Burgess, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight & Investigations; Lamar Echols, Counsel, Oversight & Investigations; Ali Fulling, Legislative Clerk, Oversight & Investigations, Digital Commerce and Consumer Protection; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; C.J. Young, Minority Press Secretary; and Perry Lusk, Minority GAO Detailee.

OPENING STATEMENT OF HON. GREGG HARPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. HARPER. I call to order the hearing of the subcommittee on Oversight and Investigations.

Today, the Subcommittee on Oversight and Investigations is holding a hearing entitled, "Examining State Efforts to Improve Transparency of Healthcare Costs for Consumers." We are here today because healthcare costs continue to rise in the United States and many Americans are struggling to budget and pay for their healthcare expenses.

According to the Centers for Medicare and Medicaid Services, we spent \$3.3 trillion on healthcare costs in 2016, which means that nearly 18 percent of the overall share of gross domestic product was related to healthcare spending. About 32 percent of healthcare spending in 2016 was on hospital care, 20 percent was on physician

and clinical services, and about 10 percent of the spending was on prescription drugs.

The Committee has been actively looking at these concerning trends and has held a number of hearings examining some of the causes of increased healthcare costs, and increasing healthcare costs. Last year, the Oversight and Investigations subcommittee held two hearings on the 340B Drug Pricing Program and issued a report with the findings from our investigations. In February, the subcommittee held a hearing examining consolidation in the healthcare market, and examined the impact of consolidation on healthcare competition and innovation.

As healthcare costs continue to rise, many Americans still have no idea how much something will cost them before they receive care. Oftentimes, they only know their out-of-pocket costs once they have gotten the care and get their bill weeks, sometimes months later. The purpose of today's hearing is to examine state laws and policies that have an impact on healthcare costs and what can be done to lower costs for all Americans through more transparency of healthcare costs.

These transparency efforts have generally attempted to provide consumers information about different types of healthcare costs, including information about the cost of healthcare services and the cost of prescription drugs. In our work, we have heard that there are a number of issues that make it difficult for some of these efforts to be effective.

For example, sometimes there may be contractual provisions that limit the sharing of certain price information or concerns that the sharing of certain price information may be anti-competitive. Moreover, healthcare billing is complex and it can be difficult to provide the information to consumers in a meaningful way that is useful to them. Similarly, only a small percentage of healthcare services may be "shoppable." I hope to hear more about some of the barriers to transparency and what, if anything, Congress can do to help.

Unfortunately, early evidence suggests that some price transparency tools have not helped facilitate price shopping and lower consumer costs. I, therefore, look forward to hearing more from the witnesses about why this is the case, and what forms of transparency might help consumers as they budget for their care and make better healthcare decisions. For example, do we need to pair transparency with some other mechanism for it to be most effective?

The cost of certain healthcare services can vary significantly in the same geographic region at different sites of care. For instance, a 2014 study by the U.S. Government Accountability Office found that the estimated cost of maternity care at select, high-quality acute care hospitals in the Boston area ranged between \$6,834 and \$21,554, over a 200 percent difference.

A more recent 2018 study found that median price of magnetic resonance imaging, an MRI, of the spine ranges from \$500 to \$1,670 in Massachusetts, also over a 200 percent difference.

Empowering consumers with more information about the cost and quality of their care helps to reduce wasteful spending and save families money.

As we move forward, we have to keep in mind that there is a delicate balance between beneficial transparency and transparency that ultimately harms competition and consumers. The Federal Trade Commission has highlighted that it is important to give consumers the precise information they need to make better healthcare decisions. The agency also has cautioned, however, that it is important to avoid broad disclosures that may chill competition in the healthcare market.

I welcome and thank the witnesses for being here today. I look forward to their testimony.

And I will now recognize Ms. Castor for purposes of an opening statement.

[The prepared statement of Mr. Harper follows:]

PREPARED STATEMENT OF HON. GREGG HARPER

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According to the Centers for Medicare and Medicaid Services, we spent \$3.3 trillion on healthcare in 2016, which means nearly 18 percent of the overall share of gross domestic product was related to healthcare spending. About 32 percent of healthcare spending in 2016 was on hospital care, 20 percent was on physician and clinical services, and about 10 percent of the spending was on prescription drugs.

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As healthcare costs continue to rise, many Americans still have no idea how much something will cost them before they receive care. Oftentimes, they only know their out of pocket costs once they have gotten the care and get their bill weeks, sometimes months, later. The purpose of today's hearing is to examine state laws and policies that have an impact on healthcare costs and what can be done to lower costs for all Americans through more transparency of healthcare costs.

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sumers with more information about the cost and quality of their care could help to reduce wasteful spending and save families money.

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I welcome and thank the witnesses for being here today, and I look forward to their testimony.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Well, thank you, Mr. Chairman. Thank you for calling this important hearing. I think it is a worthy topic.

But, I wanted to note at the outset it has been almost 1 month since the Democrats on this committee have requested an oversight hearing on the Administration's family separation policy. The Energy and Commerce Committee has primary responsibility for oversight of the Department of Health and Human Services. We have had over the last month a number of hearings on many varied topics, but none are as important as what is happening as children who are ripped away from their family. Now, courts have ordered reunification.

It is our responsibility as Members of Congress, especially in the Oversight Committee of Energy and Commerce, to have an oversight hearing to get to the bottom of this. We hear horrifying stories every day about the impact on children.

And so at this time I am going to renew the request of the Democrats on Energy and Commerce to schedule an oversight hearing as soon as possible on the family separation policy.

Now, healthcare costs, also a very worthy topic. And if we were to schedule another important oversight hearing, it certainly should be on the impact of the Trump administration's lawsuit that where they claim that preexisting conditions should not be a right of American families, especially in their healthcare policy. That would be another very worthy oversight hearing. But, right now we are here on transparency, so let's talk about that.

I understand that every family feels a very significant impact of rising prices. And part of the problem is the fact that healthcare consumers often have no visibility into how much services are actually going to cost.

And depending on multiple factors, such as where you live, your insurance, the type of provider, costs can vary greatly and are unpredictable. That makes healthcare unlike virtually any other purchase, and it makes it more difficult to constrain costs.

There are all sorts of reports out there—many of you all have experienced this—of outrageously high bills received by unsuspecting consumers. Plus, it is darn confusing sometimes. You get a bill and it says this is your responsibility, this is what is paid, and people simply don't, don't, get it.

There was a couple in California recently who were reportedly charged over \$18,000 for a 3-hour visit to an emergency room where their baby was examined, took a nap, and drank formula.

And another patient received two CT scans that varied between \$268 and \$9,000.

These shockingly high bills are frustrating and can devastate a family's finances. For that reason, greater transparency can theoretically provide consumers with more information to make decisions and to predict the costs that they are going to incur.

To that end, many states have taken some action to bring more transparency to healthcare. But it isn't always easy. My home State of Florida, for example, established a website that allows consumers to search for healthcare prices at hospitals and outpatient surgery centers in 2007, but consumers don't know about it. And one of the problems is it doesn't even contain all of the hospitals that are in your market, and it doesn't contain a lot of the leading health insurers' information in our state.

So there, Florida is currently struggling with trying to launch another healthcare transparency website but now the cost is really escalating. It has been \$4 million to get that up and running, and we don't have a lot to show for it.

Other states now require pharmaceutical companies to publicize and provide information related to large increases in prices for certain drugs. And here in the House I am a proud cosponsor of Congresswoman Schakowsky's Fair Accountability and Innovative Research Drug Pricing Act, which would require drug companies to report an increase in certain drug prices by more than 10 percent in a year to HHS, and submit transparency and justification reports before they increase the price of certain drugs by 10 percent.

We should move initiatives that can help consumers control their healthcare costs. But transparency in our healthcare system shouldn't be the only tool in our tool box. It has to be accompanied with other improvements to have a meaningful impact on the actual cost of care.

So, I am looking forward to hearing the witnesses today. I look forward to hearing from you on how we can use healthcare transparency to lower costs for our neighbors back home.

Thank you, and I yield back.

[The prepared statement of Ms. Castor follows:]

PREPARED STATEMENT OF HON. KATHY CASTOR

Thank you, Mr. Chairman. Healthcare costs continue to account for a large portion of our economy, and every family feels the impact of rising prices. Part of this problem is the fact that healthcare consumers often have no visibility into how much services are actually going to cost.

Depending on multiple factors such as the geographical area, a patient's insurance, and the type of provider, costs can vary greatly and seem unpredictable to the consumer. That makes healthcare unlike virtually any other commodity, and makes it more difficult to constrain costs.

We have seen news reports of outrageously high bills received by unsuspecting consumers. There was the couple in California who were reportedly charged over \$18,000 for a 3-hour visit to an emergency room, where their baby was examined, took a nap, and drank formula. And another patient received two CT scans that varied between \$268 and nearly \$9,000.

These shocking bills are frustrating and can devastate a family's finances. For that reason, greater transparency can theoretically provide consumers with more information to make decisions and predict the costs they are going to incur.

To that end, many states have taken some action to bring more transparency to healthcare. My home State of Florida, for example, established a website that allows consumers to search for healthcare prices at hospitals and outpatient surgery cen-

ters. Other states now require pharmaceutical companies to publicize and provide information related to large increases in prices for certain drugs.

These efforts are well-intended, and we should applaud any initiative that has the potential to help consumers control their healthcare costs. That being said, we also must keep in mind that transparency is not a panacea, and must be coupled with other improvements to have a meaningful impact on the actual cost of care.

As we will hear from the witnesses today, transparency initiatives by themselves are not tremendously effective at bringing down consumer healthcare costs. What sounds like a straightforward solution in most markets does not always work in healthcare, for multiple reasons.

For one thing, when people's health is at stake, information on prices might not be relevant. People naturally trust their doctor and want the best care. And when we see greater consolidation in the healthcare industry, transparency cannot provide much help to consumers with no leverage to access lower prices.

So we need to consider what the research says: what types of transparency reforms can work, what does not work, and how transparency needs to be combined with more meaningful actions.

For instance, Mr. Chairman, a key part of bringing down costs for consumers is ensuring access to high-quality and affordable healthcare, including primary care. We need to give consumers more than just information—we need to bring relief from these rising costs in the first place. Without that, these transparency efforts will be in vain, and we'll just be shining a spotlight on continuously increasing costs.

That is not to say that transparency does not have a role. Instead, we should look to combine transparency initiatives with incentives to provide higher quality care at lower costs. I hope to hear the witnesses' perspective on that today.

I thank the witnesses for being here today, and I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Mr. Walden, for 5 minutes.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you very much, Mr. Chairman. I appreciate your holding this hearing on the various transparency efforts at the state level to engage patients in healthcare decision making processes.

As Chairman Harper mentioned in his opening statement, healthcare costs are increasing and are expected to continue to rise. In 2016, the U.S. spent approximately \$3.3 trillion on healthcare, and the Center for Medicare and Medicaid Services, CMS, estimates that spending will reach \$5.7 trillion in 2026.

Healthcare costs are having a substantial impact on the budgets of American families and individuals. In addition to health insurance premiums increasing, patients are also directly responsible for more of their healthcare costs. In 2016, about 11 percent of the \$3.3 trillion spent on healthcare was paid for directly by consumers through out-of-pocket costs, which was about \$352 billion.

Unsurprisingly, as healthcare costs increase, most patients want to know more about how much different medical services and products are going to cost them. We all do. That is why we are having this hearing. I have heard numerous stories about individuals who were going to have a medical procedure or lab work performed, found it nearly impossible, and in some instances literally impossible, to learn how much it was going to cost them before they got the care. A lot of doctors don't even know how much different services are going to cost.

Many states have adopted policies to prohibit some types of "gag clauses" and help patients get access to the prices for prescription

drugs. Twenty-two states have passed legislation prohibiting clauses in contracts that prohibit pharmacists from telling patients price options for their prescription medicine.

In addition to these recent efforts to encourage price information sharing with patients at the pharmacy counter, several states have engaged in efforts to provide patients with more information about the price and quality of different healthcare services. Some of these efforts include creating websites that give patients information about the prices of different procedures, requiring insurers to provide these tools to their members, and requiring providers to give patients information about the estimated prices for their treatment before they get the treatment. Unfortunately, to date, some of the preliminary evidence has shown that these tools haven't been very effective in getting patients to price shop.

If we are going to successfully reduce healthcare costs, we need to empower patients and we need to engage them in the decision-making process. So there needs to be greater transparency so patients can have more information about the prices for different medical products and services, and that information needs to be given to them in a meaningful way.

Given that some of the existing price transparency tools are still able to be improved, I am eager to hear from our witnesses today about why there are some of these barriers, and then also what else we can do to empower patients with the information. I also want to hear about the role the Federal Government can play in promoting transparency and making patients more informed about the cost of their care.

Patients should be able to learn about how much something is going to cost before they get it. This includes having information about different price options for prescription drugs at the pharmacy counter, and information about different procedures and lab work, among other things.

So, we have got a lot of questions for our witnesses today. We really appreciate your being here. But one of my main questions is what is the best way for patients to get healthcare price information, and how can we empower the consumer?

I am also interested in hearing about any market behaviors that work against transparency and ultimately harm any attempts to bring down healthcare costs.

So, thanks for being here. This is a big priority for me and for the committee to look into all the costs of healthcare.

With that I will just warn you, I have got another hearing going on downstairs so I have to bounce back and forth. But I will yield the balance of my time to Dr. Burgess, who chairs our Health Subcommittee.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman, for holding this hearing on the various transparency efforts at the state level to engage patients in the healthcare decision-making process.

As Chairman Harper mentioned in his opening statement, healthcare costs are increasing and are expected to continue to rise. In 2016, the U.S. spent approximately \$3.3 trillion on healthcare, and the Centers for Medicare and Medicaid Services (CMS) estimates that spending will reach \$5.7 trillion by 2026.

Healthcare costs are having a substantial impact on the budgets of American families and individuals. In addition to health insurance premiums increasing, patients are also directly responsible for more of their healthcare costs. In 2016, about 11 percent of the \$3.3 trillion spent on healthcare was paid for directly by consumers through out-of-pocket costs—which was about \$352 billion dollars.

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Many states have adopted policies to prohibit some types of “gag clauses” and help patients get access to the prices for prescription drugs. Twenty-two states have passed legislation prohibiting clauses in contracts that prohibit pharmacists from telling patients price options for their prescription medicine.

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If we're going to successfully reduce healthcare costs, we need to empower patients and engage them in the decision-making process. There needs to be greater transparency, so patients can have more information about the prices for different medical products and services, and that information needs to be given to them in a meaningful way.

Given that some of the existing price transparency tools are still able to be improved, I'm eager to hear from the witnesses today about why there are some of these barriers and then also what else we can be doing to empower patients with information. I also want to hear about the role that the federal government can play in promoting transparency and making patients more informed about the cost of their care.

Patients should be able to learn about how much something is going to cost them before they get it. This includes having information about different price options for prescription drugs at the pharmacy counter and information about different procedures and lab work, among other things.

I have a lot of questions for the witnesses today, but one of my main questions is what is the best way for patients to be getting healthcare price information and how can we help empower patients? I also am interested in hearing about any market behaviors that work against transparency and ultimately harm any attempts to bring down healthcare costs.

I'd like to thank our witnesses for being with us today, and look forward to their feedback on those questions and others. There is clearly a lot to be discussed in regards to today's topic, and I look forward to a robust dialogue.

Mr. BURGESS. Well, thank you, Mr. Chairman. And, Mr. Chairman, it is my fondest wish that one day I will come into a hearing in the Energy and Commerce Committee and there will be five doctors at the witness table, and they are going to expound for us on how much economists should be paid. I am still waiting for that hearing. We haven't had it yet.

Thanks to our witnesses for being here today. And, Mr. Chairman, to you I have a couple of things that I would just like to place into the record.

This is a copy of H.R. 5547, a bill that was introduced in the last Congress by Mr. Green and I that dealt with transparency. And, in fact, Mr. Green and I have been working on transparency for the past several years. And a version of this was actually included as an amendment in the Affordable Care Act, but I think it got lost on its way to the Senate.

Mr. HARPER. Without objection.
[The information follows:]



I

114TH CONGRESS
2D SESSION

H. R. 5547

To amend title XIX of the Social Security Act to provide for increased price transparency of hospital information and to provide for additional research on consumer information on charges and out-of-pocket costs.

IN THE HOUSE OF REPRESENTATIVES

JUNE 21, 2016

Mr. BURGESS (for himself and Mr. GENE GREEN of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title XIX of the Social Security Act to provide for increased price transparency of hospital information and to provide for additional research on consumer information on charges and out-of-pocket costs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Health Care Price
5 Transparency Promotion Act of 2016”.

1 **SEC. 2. INCREASING THE TRANSPARENCY OF INFORMA-**
2 **TION ON HOSPITAL CHARGES AND MAKING**
3 **AVAILABLE INFORMATION ON ESTIMATED**
4 **OUT-OF-POCKET COSTS FOR HEALTH CARE**
5 **SERVICES.**

6 (a) IN GENERAL.—Title XIX of the Social Security
7 Act is amended—

8 (1) in section 1902(a) (42 U.S.C. 1396a(a)), by
9 inserting after paragraph (77) the following new
10 paragraph:

11 “(78) provide that the State will establish and
12 maintain laws, in accordance with the requirements
13 of section 1921A, to require disclosure of informa-
14 tion on hospital charges, to make such information
15 available to the public, and to provide individuals
16 with information about estimated out-of-pocket costs
17 for health care services;” and

18 (2) by inserting after section 1921 (42 U.S.C.
19 1396r-2) the following new section:

20 “INCREASING THE TRANSPARENCY OF INFORMATION ON
21 HOSPITAL CHARGES AND PROVIDING CONSUMERS
22 WITH ESTIMATES OF OUT-OF-POCKET COSTS FOR
23 HEALTH CARE SERVICES

24 “SEC. 1921A. (a) IN GENERAL.—The requirements
25 referred to in section 1902(a)(78) are that the laws of a
26 State must—

1 “(1) in accordance with subsection (b)—

2 “(A) require the disclosure of information
3 on hospital charges; and

4 “(B) provide for access to such informa-
5 tion; and

6 “(2) in accordance with subsection (c), require
7 the provision of a statement of the estimated out-of-
8 pocket costs of an individual for anticipated future
9 health care services.

10 “(b) INFORMATION ON HOSPITAL CHARGES.—The
11 laws of a State must—

12 “(1) require disclosure, by each hospital located
13 in the State, of information on the charges for cer-
14 tain inpatient and outpatient hospital services (as
15 determined by the State) provided at the hospital;
16 and

17 “(2) provide for timely access to such informa-
18 tion by individuals seeking or requiring such serv-
19 ices.

20 “(c) ESTIMATED OUT-OF-POCKET COSTS.—The laws
21 of a State must require that, upon the request of any indi-
22 vidual with health insurance coverage sponsored by a
23 health insurance issuer, the issuer must provide a state-
24 ment of the estimated out-of-pocket costs that are likely
25 to be incurred by the individual if the individual receives

1 particular health care items and services within a specified
2 period of time.

3 “(d) RULES OF CONSTRUCTION.—Nothing in this
4 section shall be construed as—

5 “(1) authorizing or requiring the Secretary to
6 establish uniform standards for the State laws re-
7 quired by subsections (b) and (c);

8 “(2) requiring any State with a law enacted on
9 or before the date of the enactment of this section
10 that—

11 “(A) meets the requirements of subsection
12 (b) or subsection (c) to modify or amend such
13 law; or

14 “(B) meets some but not all of the require-
15 ments of subsection (b) or subsection (c) to
16 modify or amend such law except to the extent
17 necessary to address the unmet requirements;

18 “(3) precluding any State in which a program
19 of voluntary disclosure of information on hospital
20 charges is in effect from adopting a law codifying
21 such program (other than its voluntary nature) to
22 satisfy the requirement of subsection (b)(1); or

23 “(4) guaranteeing that the out-of-pocket costs
24 of an individual will not exceed the estimate of such
25 costs provided pursuant to subsection (c).

1 “(e) DEFINITIONS.—For purposes of this section:

2 “(1) The term ‘health insurance coverage’ has
3 the meaning given such term in section 2791(b)(1)
4 of the Public Health Service Act.

5 “(2) The term ‘health insurance issuer’ has the
6 meaning given such term in section 2791(b)(2) of
7 the Public Health Service Act, except that such term
8 also includes—

9 “(A) a Medicaid managed care organiza-
10 tion (as defined in section 1903(m)); and

11 “(B) a Medicare Advantage organization
12 (as defined in section 1859(a)(1), taking into
13 account the operation of section 201(b) of the
14 Medicare Prescription Drug, Improvement, and
15 Modernization Act of 2003).

16 Section 1856(b)(3) shall not preclude the application
17 to a Medicare Advantage organization or a Medicare
18 Advantage plan offered by such an organization of
19 any State law adopted to carry out the requirements
20 of subsection (b) or (c).

21 “(3) The term ‘hospital’ means an institution
22 that meets the requirements of paragraphs (1) and
23 (7) of section 1861(e) and includes those to which
24 section 1820(c) applies.”.

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the amendments made by subsection (a)
3 shall take effect on October 1, 2017.

4 (2) EXCEPTION.—In the case of a State plan
5 for medical assistance under title XIX of the Social
6 Security Act which the Secretary of Health and
7 Human Services determines requires State legisla-
8 tion (other than legislation appropriating funds) in
9 order for the plan to meet the additional require-
10 ments imposed by the amendment made by sub-
11 section (a), the State plan shall not be regarded as
12 failing to comply with the requirements of such title
13 solely on the basis of its failure to meet these addi-
14 tional requirements before the first day of the first
15 calendar quarter beginning after the close of the
16 first regular session of the State legislature that be-
17 gins after the date of the enactment of this Act. For
18 purposes of the previous sentence, in the case of a
19 State that has a 2-year legislative session, each year
20 of such session shall be deemed to be a separate reg-
21 ular session of the State legislature.

1 **SEC. 3. RESEARCH ON INFORMATION VALUED BY CON-**
2 **SUMERS ON CHARGES AND OUT-OF-POCKET**
3 **COSTS FOR HEALTH CARE SERVICES.**

4 (a) RESEARCH ON INFORMATION VALUED AND USED
5 BY CONSUMERS.—The Director of the Agency for
6 Healthcare Research and Quality (in this section referred
7 to as “AHRQ”) shall conduct or support research, pursu-
8 ant to section 901(b)(1)(D) of the Public Health Service
9 Act (42 U.S.C. 299(b)(1)(D)), on—

10 (1) the types of information on the charges, and
11 out-of-pocket costs, for health care services that in-
12 dividuals find useful in making decisions about
13 where, when, and from whom to receive care;

14 (2) how the types of information valued by indi-
15 viduals for making such decisions vary by whether
16 they have health benefits coverage and, if they do,
17 the type of such coverage they have, such as tradi-
18 tional insurance, health maintenance organizations,
19 preferred provider organizations, and high deductible
20 plans coupled with health savings accounts; and

21 (3) ways in which such information may be
22 made available on a timely basis and in easy-to-un-
23 derstand form to individuals facing such decisions.

24 (b) REPORT.—The Director of AHRQ shall report to
25 the Congress on the results of such research not later than
26 18 months after the date of the enactment of this Act,

1 together with recommendations for ways in which the Fed-
2 eral Government can assist the States in achieving the ob-
3 jective specified in subsection (a)(3).

4 (c) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as may be
6 necessary to carry out this section.

○

Mr. BURGESS. Also, I would like to place for the record, I printed off some sheets from a website called txpricepoint.org. Texas PricePoint is a website that is at the least sponsored by the Texas Hospital Association, and it is useful information for your county or for your city, for the hospital in your county or for your city.

For example, I printed off a sheet that I will, I will leave for the record that deals with the cost of an uncomplicated cesarean section in the hospital where I used to practice. And I note that although my hospital is a little lower than some of the other hospitals in the area, it is higher than other hospitals in the State.

And as a physician, I also will submit to you that is useful information. And if recognizing the decision that a patient makes to go to a hospital is likely driven by the physician, making this type of information more available to physicians perhaps could help with physician behavior as far as directing the course for hospital care.

So, I ask unanimous consent to place this into the record, and look forward to hearing from our witnesses.

Ms. DEGETTE. Mr. Chairman, I reserve the right to object till I review the documents, although I am sure they will be fine. If I could just review the documents.

Mr. HARPER. Well, as we review that we will come back to approving the entering that into the record as soon as Ms. DeGette has had an opportunity to review that.

I will now recognize Mr. Pallone, the Ranking Member, for purposes of an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

The cost of healthcare is consistently a top concern for American families. But all too often, consumers face an initial problem before they even receive care, knowing how much a certain healthcare service is going to cost them. And that is because there are so many players in the healthcare industry making it difficult to bring clear cost transparency to the consumer.

Two different patients can receive the same service from a doctor but end up being charged starkly different prices. And this makes it difficult for a patient to make an informed decision about their care.

There are multiple factors contributing to this lack of transparency in healthcare. For example, a provider may have a set of rates it changes for private-pay customers, but depending on a person's insurance and deductible, their price could vary greatly.

This differs from most other markets the consumer has a clear understanding of how much a product or service will cost, and can shop around to obtain the best deal. The nature of healthcare makes this more complicated. And it is particularly noticeable in emergency situations where a patient's top concern is receiving the lifesaving care they need, rather than what the care will cost. In other expensive specialties such as oncology, patients trust their doctors to provide them with referrals based on quality of care.

With that being said, consumers can certainly benefit from more information, and there are opportunities to bring more trans-

parency to the healthcare industry. As we will hear from the witnesses today, just about every state has implemented some type of transparency initiative. For instance, my home State of New Jersey recently passed a law requiring providers to notify patients if they are out-of-network, helping to avoid surprise bills for patients.

Many states have also created websites that post the prices of common procedures, and allow consumers to browse the prices of various providers. And this kind of reform can empower consumers just by giving them greater access to information.

So, I look forward to hearing from the witnesses what the research says about these efforts, and what other reforms are being attempted in other states. However, we should be cautiously optimistic about greater transparency, as we have seen only modest results in actually bringing down costs. Some studies have found an increase in prices with more transparency, so we should be mindful of these results before considering any reforms.

I also think it is important that we keep the big picture in mind here. It is one thing to bring more transparency to healthcare, and give consumers information on what they are being charged, but we should also encourage meaningful efforts to actually reduce healthcare costs for American families.

And one of the primary ways to do that is by ensuring access to affordable health coverage. Whether it be Medicaid, essential health benefits in private insurance, or a robust marketplace for individuals who shop for insurance, transparency matters only if consumers have access to high-quality, affordable healthcare.

And, finally, while I appreciate the efforts of this subcommittee to explore these issues, I would be remiss if I did not note that there is an emergency taking place right now within HHS that this committee should be holding an oversight hearing on. Today, there are still more than 2,500 children in the custody of HHS who have yet to be reunited with their families after being forcibly separated by the Trump administration. This committee has a responsibility to conduct vigorous oversight of the Federal Government, and today would have been a perfect day to have HHS Secretary Azar and Scott Lloyd, the Director of the Office of Refugee Resettlement to be here.

So, I again urge the Republican majority to schedule a hearing as soon as possible so we can work to fix this crisis, and so we can finally get some answers.

I don't know if anybody wants my time. If not, I will yield back. Thank you, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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I again urge the Republican Majority to schedule a hearing as soon as possible so we can work to fix this crisis, and so we can finally get answers.

Mr. HARPER. The gentleman yields back.

Ms. DEGETTE. Mr. Chairman, I withdraw my right to object. I have no objection to these documents from Mr. Burgess.

Mr. HARPER. The documents are so entered.

[The information appears at the conclusion of the hearing.]

Mr. HARPER. I ask unanimous consent that the members' written opening, opening statements be made part of the record.

Without objection, they will be entered into the record.

Mr. HARPER. I would now like to introduce our witnesses for today.

Today we have Dr. Jaime King, Professor at UC Hastings College of Law; and Dr. Michael Chernew, Professor at the Department of Health Care Policy at Harvard Medical School.

Unfortunately, our third witness, Dr. Kavita Patel, was unable to be here today due to a family emergency. And Dr. Patel and her family will remain in our thoughts and prayers as we send them our best wishes.

You are both aware that the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do either of you have any objection to testifying under oath?

Mr. CHERNEW. No objection.

Ms. KING. No objection.

Mr. HARPER. Both witnesses have stated no.

The Chair then advises you that under the rules of the House and the rules of the committee you are entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

Mr. CHERNEW. No.

Ms. KING. No.

Mr. HARPER. Both witnesses have responded no.

In that case, if you would please rise and raise your right hand and I will swear you in.

[Witnesses sworn.]

Mr. HARPER. You may be seated.

You are now under oath and subject to the penalties set forth in Title 18, Section 1001, of the United States Code. You may now each give a five-minute summary of your written statement. And Dr. King, we will recognize you for 5 minutes.

STATEMENT OF JAIME KING, PH.D., PROFESSOR, UC HASTINGS COLLEGE OF LAW; AND MICHAEL CHERNEW, PH.D., PROFESSOR, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

STATEMENT OF JAIME KING

Ms. KING. Thank you. Committee Chairman Walden, Subcommittee Chairman Harper, Committee Ranking Members Pallone and DeGette, Subcommittee Chairmen Griffith and Castor, and members of the Subcommittee on Oversight and Investigations, I very much appreciate the opportunity to testify on price transparency in the healthcare market today.

As you know, the cost of healthcare in the United States currently threatens the economic stability of our citizens, our businesses, and our nation. A 2018 Gallup poll found that more Americans worry about the availability and affordability of healthcare than any of the 14 other major social issues, like crime, the economy, and the availability of guns.

Economic theory suggests that if consumers had better access to price information prior to choosing providers and receiving healthcare services that they would choose less expensive options, thereby lowering overall healthcare spending. As a result, states have been very active in this endeavor, introducing 163 price transparency bills so far in 2018.

Historically, most state price transparency initiatives have focused on changing consumer behavior to encourage them to select providers and services that offer the greatest value at the lowest cost. Yet, health services research examining the impact of these efforts suggest that most of them have not engaged patients in a sufficient way to curb healthcare spending. Controlling healthcare spending requires engagement not just from patients but from all actors in the healthcare market: providers, payers, and policy makers.

Twenty states, including Oregon, Maryland, Maine, and New Hampshire, have all developed All Payer Claims Databases which

collect information on both healthcare services Americans use, and amounts paid for those services. States can use these healthcare claims data to report better reporting to an All Care Claims Database, to inform patient and provider decisions regarding care; to allow payers to compare their rates to make sure that they are getting, you know, close to average or somewhere in there; and to allow policy makers to examine the drivers of healthcare costs over time; evaluate the effectiveness of various reform efforts; and measure the impact of mergers and acquisitions on healthcare price and quality.

However, legal barriers including contractual provisions, ERISA preemption, and trade secret laws currently hinder the utility of many existing price transparency initiatives.

So, what can Congress do? For transparency initiatives to achieve their full effect at the state level, changes are needed at the Federal level. And, fortunately, Congress has the ability to address some of the most significant barriers to price transparency. There are five things Congress can do to improve healthcare price transparency:

Number one, and most important, address the ERISA preemption challenges. The main goal of ERISA is to promote uniformity in state regulations governing employee benefit plans. But over time, ERISA's preemptive reach has expanded in ways that put this goal of uniformity for employers over transparency, competition, and affordability of healthcare for all Americans.

The Supreme Court decision in *Gobeille v. Liberty Mutual Insurance* held that ERISA preempted state All Payer Claims Databases, preempted their reporting requirements as applied to self-insured employer plans. And this decision left state All Payer Claims Databases without healthcare claims data for about a third of their population, which greatly limits their accuracy and their utility.

Essentially, trying to analyze the healthcare landscape using data from an All Payer Claims Database without the self-insured employer population is kind of akin to Google Maps, trying to use Google Maps without a third of the road; right?

Enabling All Payer Claims Databases to collect the full set of healthcare claims data would dramatically increase the utility and reliability of these initiatives. While addressing ERISA preemption of state health reform laws is the most important thing that Congress can do to promote price transparency and bring down healthcare costs, additional actions by Congress could also help illuminate healthcare prices, which brings me to number two.

Congress should seek to encourage price shopping incentives like reference pricing, rewards, and shared networks, through demonstration and pilot projects.

Number three, Congress should create a public interest exemption to the Defend Trade Secrets Act of 2016. Healthcare providers and insurers currently invoke trade secrets protection to avoid disclosing negotiated healthcare prices and other information to consumer, employers, researchers, and state officials.

Trade secrets protections were designed to encourage and protect innovation, like the Coca-Cola formula, not to permit Coca-Cola and restaurateurs to hide its price on the menu and then after you eat your meal give you a bill for a \$25 Coke. Right?

Number four, Congress should require manufacturers of electronic medical records and insurance companies to establish uniform standards of interoperability and standard bundles of care for billing purposes so that providers and patients can access meaningful and actionable information about the cost to the patient, who and what is in the patient's network, and the quality of providers and services being offered to them when the provider is making referrals during appointments.

And, number five, they should develop billing codes for a physician's time spent in these efforts.

Thank you.

[The prepared statement of Ms. King follows:]

Testimony of:

Jaime S. King

**Examining State Efforts to Improve Transparency in Healthcare Costs for
Consumers**

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

U.S. House of Representatives

Tuesday, July 17, 2018

Summary of Testimony

The United States currently spends more than any other nation on healthcare, as a percentage of gross domestic product and per capita. Our healthcare markets suffer from high levels of consolidation, a lack of clear price and quality signals for consumers, and an inability to access price, utilization, and quality data. Price transparency initiatives, like all payer claims databases, can improve healthcare market functioning in all these areas by providing relevant information to decision-makers, including patients, providers, payers, and policymakers, at key decision points. Historically, most price transparency initiatives have focused on changing consumer behavior to encourage them to select providers and services that provide the greatest value at the lowest cost. Unfortunately, these initiatives have not been successful at bending the cost curve due to limited usage and mixed levels of effectiveness. Price transparency initiatives that provide patient, provider, procedure, and plan level of specificity on price and quality to consumers, accompanied by a financial incentive, like reference pricing or tiering, have proven more effective. However, even with these potential improvements, legal barriers including contractual provisions, ERISA preemption, and trade secrets laws continue to hinder the utility of many existing price transparency initiatives.

Congress, more than any other entity, has the ability to address the most significant barriers to price transparency in healthcare and maximize the tremendous untapped potential of existing state initiatives, in particular APCDs. To do so, Congress should narrow ERISA preemption to exclude state health reform efforts that do not unduly burden ERISA's goal of uniformity for employer-based benefit plans, while also granting states sufficient flexibility to achieve their health reform goals.

Testimony of Jaime S. King

Committee Chairman Walden, Subcommittee Chairman Harper, Committee Ranking Member Pallone, Subcommittee Ranking Member Degette, and Members of the Subcommittee on Oversight and Investigations, I very much appreciate the opportunity to testify on the role of price transparency in the healthcare market. I am a professor of law and the Bion M. Gregory Chair in Business Law at the University of California, Hastings College of the Law. I have written and taught in the field of health law and policy for the last ten years. I am also the Associate Dean and Co-Director of the UCSF/UC Hastings Consortium on Law, Science and Health Policy, and the Co-Founder and Executive Editor of The Source on Healthcare Price and Competition, a free and independent academic website that posts news, academic articles, legislative developments, litigation documents, original analysis, and guest commentary on healthcare price and competition. I owe a great deal of thanks to Katherine Gudiksen, Laura Hagen, Erin Fuse Brown, Anna Sinaiko, and everyone at The Source on Healthcare Price and Competition who contributed their time, effort, and research to this testimony.

Introduction

The cost of healthcare in the United States currently threatens the economic stability of our citizens, our businesses, our state and local governments, and our nation. The United States spends more on healthcare than on any other sector of the economy, including defense, transportation, education, or housing. A 2018 Gallup poll found that a greater percentage of Americans (55%) stated that they worry “a great deal” about the availability and affordability of healthcare than fourteen other major social issues, like crime, the economy, unemployment, terrorist attacks, and the availability of guns.¹ In 2017, projected U.S. spending on healthcare

¹ Jeffrey Jones, *U.S. Concerns About Healthcare High; Energy, Unemployment Low*, GALLUP (March 26, 2018), <https://news.gallup.com/poll/231533/concerns-healthcare-high-energy-unemployment-low.aspx>.

goods and services approached \$3.5 trillion.² This amounts to more than any other economically developed country, both as a percentage of GDP and per capita.³ Despite this, the health of Americans is not significantly better than that of our counterparts in countries like the U.K. or Canada. In fact, on many key metrics we are falling behind.⁴

When faced with how to address growing healthcare costs, academics and policymakers frequently focus on ways to address market inefficiencies and failures. One market failure that has received a great deal of attention in recent years is the lack of price transparency in the healthcare market. Nearly every day a news story reveals the plight of Americans facing astronomical healthcare bills that seem to have little to no relation to the cost of providing the services received and come as a complete shock to consumers. For instance, Peter Drier of New York was blindsided by a medical bill of about \$117,000 from an “assistant surgeon” who the primary surgeon called in while Mr. Drier was receiving neck surgery. Each surgeon billed for each step of the procedure. The primary surgeon billed \$74,000 for removing two disks and an additional \$50,000 for placing the hardware, while the assistant billed \$67,000 and \$50,000 for those tasks. The primary surgeon accepted a negotiated fee determined through Mr. Drier’s insurance company which was about \$6,200. However, because the assistant surgeon was out-of-network, he charged \$117,000. Had Mr. Drier been a Medicare beneficiary, the assistant would have only been able to bill 16% of the primary surgeon’s fee – roughly \$800, less than 1% of

² CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES FACT SHEET, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last modified Apr. 17, 2018).

³ ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT, SPENDING ON HEALTH: LATEST TRENDS, June 2018, <http://www.oecd.org/health/health-systems/health-data.htm>.

⁴ Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, 319 JAMA 10, 1024-39 (2018); Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, N.Y. TIMES (May 14, 2018), <https://www.nytimes.com/2018/05/14/upshot/medical-mystery-health-spending-1980.html>.

what the assistant surgeon was actually paid.⁵ In an effort to protect patients like Mr. Drier from these astronomical fees, and twenty-four states enacted legislation prohibiting surprise billing of patients.⁶

Economic theory suggests that if consumers had better access to price information prior to choosing providers and receiving healthcare services, they would choose less expensive providers and services, and thereby lower overall healthcare spending. Empirical studies on price transparency in other markets show that transparency initiatives tend to lead to more consistent, lower prices.⁷ As a result, price transparency has become a “cornerstone of the consumer-directed healthcare model,” with policymakers, insurers, private entities, state and local governments, and consumer advocacy organizations investing significant time, resources, and capital to promote consumer-focused price transparency in healthcare.⁸ Yet, health services research examining the impact of these efforts suggests that most of them have not engaged patients in a sufficient way to curb healthcare spending.⁹

Controlling healthcare spending requires engagement from all stakeholders in the healthcare market – patients, providers, payers, and policymakers. Price transparency initiatives, such as all payer claims databases (APCDs), have great potential to provide critical data to guide

⁵ Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 14, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

⁶ See Kevin Lucia et al., *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*, THE COMMONWEALTH FUND (June 13, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer> for a description of 21 states that had balance billing laws in 2017. Since the report was issued, Tennessee (HB 1935/SB 1969), Minnesota (SF 3480), and Missouri (SB 982) have passed balanced billing laws and Colorado (SB 146/HB 1282), New Hampshire (HB 1782/HB 1809), and New Jersey (AB 2039) have strengthened theirs.

⁷ D. ANDREW AUSTIN & JANE G. GRAVELLE, CRS Report for Congress: Does Price Transparency Effect Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector (2008) [hereinafter CRS Report for Congress].

⁸ A. Mehrotra et al., *Promise and Reality of Price Transparency*, 378 N. ENGL. J. MED. 14, 1348 (2018).

⁹ See, e.g., A. Mehrotra et al., *Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?*, 51 INQUIRY: THE J. OF HEALTH CARE ORG., PROVISION, AND FINANCING, 0046958014561496 (2014); S. Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 JAMA 17, 1874-81 (2016).

healthcare reform efforts, inform analysis on the drivers of healthcare costs, and help patients and providers choose high-value/lower-cost treatment options. However, currently the amount and quality of data available to patients and their doctors and laws restricting data collection limit even premier price transparency tools.

My testimony today will provide an overview of existing price transparency tools, and then focus on how improved transparency can benefit healthcare decision-making by targeting different information to stakeholders. I will then discuss why many prior attempts at improving price transparency have not achieved their goals, and what Congress can do to promote price transparency in healthcare.

Summary of Key Points

- Price transparency initiatives can improve healthcare market functioning by providing relevant information to decision-makers, including consumers, providers, insurers, employers, and policymakers, at key decision points.
- Historically, most price transparency initiatives have focused on changing consumer behavior to encourage them to select lower priced providers and services. These initiatives have had limited usage and mixed results.
- Price transparency initiatives that provide patient, provider, procedure, and plan level of specificity on price and quality to consumers, accompanied by a financial incentive, like reference pricing or tiering, have proven more effective.
- Legal barriers including contractual provisions, ERISA preemption, and trade secrets laws hinder the effectiveness of many existing price transparency initiatives.
- Congress has a range of options in how it can promote price transparency to improve healthcare decision-making and lower costs, but the most important and effective act it

could take is to leverage existing state efforts and resources by amending ERISA to narrow its preemption of state health reform efforts, especially those targeting transparency.

Overview of State Price Transparency Initiatives

Over the last ten years, states have passed laws to reduce the barriers to price transparency and developed statewide databases of healthcare claims data to allow for comparison and analysis of healthcare price, quality, and utilization data. State governments have refined their transparency tools over time to improve their utility and to respond to particularly pressing issues. So far in 2018, state legislatures have introduced 163 healthcare price transparency bills (see Appendix A). A large percentage of these bills focused on addressing transparency in pharmaceutical drug prices, but states have also introduced a wide swath of non-pharmaceutical price transparency bills. Recent state-based efforts include implementing and expanding APCDs, giving consumers new tools to access and compare prices for both insurance plans and healthcare services, and incentivizing patients to shop for higher-value services. Finally, many states recently passed laws protecting patients from surprise or balance billing practices, and laws prohibiting anti-competitive contract terms like gag clauses and anti-tiering/anti-steering clauses. This section will highlight some of the most common state transparency initiatives.

All Payer Claims Databases

All Payer Claims Databases (APCDs) are the cornerstone of many comprehensive price transparency initiatives. Their importance to developing consumer shopping tools, public informational tools, healthcare cost control efforts, and overall competition in healthcare markets cannot be overstated. An APCD is a comprehensive collection of medical claims data from both

public and private payers with information specific to individual plans, patients, and procedures. Consumers can use the data in APCDs to shop for higher value health services or providers. In addition, data from APCDs can be used to inform state policymakers about the operation of healthcare markets in the state.

While APCDs are instrumental tools for consumer shopping, they typically collect information on the services provided and the *amounts paid* for those services, rather than the *fees charged*. Insurance companies negotiate significant discounts from retail or “chargemaster” rates, and so such rates rarely provide the critical pricing information that patients and policymakers need. Providing both negotiated prices and amounts paid, on the other hand, paints a much clearer picture, though they are notoriously difficult to access.

To obtain such information, many states have mandated health plans to report their prices to the state APCD, while others permit them to submit the information voluntarily. Maine established the first statewide APCD in 2003, and twenty states now have or are implementing statewide APCDs with mandatory submission, and seven more states have APCDs with voluntary submission.¹⁰ States with mandatory reporting requirements have more comprehensive data. States with only voluntary reporting mechanisms only receive a portion of the picture, which will, almost assuredly, not prove representative of the entire population. For example, Oklahoma’s voluntary APCD covers only 1 million people, or approximately 25% of the population,¹¹ and therefore risks giving misleading information.

The demand for more reliable information about costs is growing and experts predict that over half the states will have an APCD or APCD-like database by 2022 that will cover at least

¹⁰ The states with APCDs that require submission are: AR, CO, CT, DE, FL, HI, KS, ME, MD, MA, MN, NH, NY, OR, RI, TN, UT, VT, WA, WV. The states with voluntary APCDs are: CA, MI, OK, SC, VA, WI, WY. <https://www.apcdouncil.org/>.

¹¹ *Oklahoma*, APCD COUNCIL, <https://www.apcdouncil.org/> (last visited July 11, 2018).

two-thirds of their populations.¹² States will continue to improve and refine their APCDs. However, the reliability and utility of state APCDs are compromised by their inability to obtain a comprehensive set of claims data because ERISA preempts any state law requiring self-insured employers to submit healthcare claims data. Nonetheless, the experience of many states demonstrates the power of APCDs to both help patients shop for higher value care and strengthen analysis of a state's healthcare market.

Price Comparison Tools

Once established, states can use the data collected in their APCD to create price comparison tools and incentives for patients to find the best value providers. For example, NH Health Cost, New Hampshire's APCD-based consumer-facing website, allows consumers, health plan enrollees, and employers to select different carriers while comparing prices.¹³ Importantly, because NH Health Cost has access to the insurer's negotiated prices with in-network providers, it can provide consumers with personalized out-of-pocket cost information for a particular procedure with a particular provider. New Hampshire's website is also one of the few publicly available sites that allows employers or payers to compare their rates to the median rate for a given service at a particular provider (e.g., a colonoscopy at the same hospital for each major insurer). Even with the desire and expertise, New Hampshire has struggled to offer this level of detailed information for each patient as benefit designs evolve to include options like value-based payments.¹⁴

¹² Joel Ario & Kevin McAvey, *Transparency in Health Care: Where We Stand And What Policy Makers Can Do Now*, HEALTH AFFAIRS BLOG (July 11, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180703.549221/full/>.

¹³ NH HEALTH COST, <https://nhhealthcost.nh.gov/> (last visited July 11, 2018).

¹⁴ Ario & McAvey, *supra* note 13.

Massachusetts, another pioneer in building and refining APCDs, also requires mandatory submission of healthcare claims data and records of services provided from public and private payers, including commercial health plans, Medicare, and MassHealth.¹⁵ However, Massachusetts' APCD, maintained by the Center for Health Information and Analysis (CHIA),¹⁶ does not offer the same connectivity with specific insurance plans as New Hampshire's APCD does. Instead, CHIA's healthcare transparency tool, MassCompareCare, includes a procedure pricing tool. This tool uses data extracted from the state's 2015 APCD and displays, by insurer, the median payment to any provider for any of 295 services. Additionally, it supplies quality information about different providers.

While these consumer-facing websites offer patients pricing information for different providers and services, few patients have engaged with them, for reasons I discuss below, and states have begun to try to incentivize patient engagement.

Right to Shop Laws

"Right to Shop" laws attempt to engage patients by giving them the ability to benefit financially when they choose lower-cost care. In New Hampshire, for example, consumers who successfully select a provider/service at a lower price receive a share of the savings in cash.¹⁷ Maine adopted a similar Right to Shop law in 2017 with transparency provisions that require insurers to give patients access to anticipated charges and estimated out-of-pocket charges in advance of receiving care. The law also requires carriers with small business group plans to offer plans that give financial incentives to patients who choose a high-quality, low-cost provider, and

¹⁵ In Massachusetts, Medicaid and Children's Health Insurance Program (CHIP) are combined into one program called MassHealth. *MassHealth*, MASS.GOV, <https://www.mass.gov/topics/masshealth> (last visited July 11, 2018).

¹⁶ CHIA, <http://www.chiamass.gov/> (last visited July 11, 2018).

¹⁷ N.H. REV. STAT. ANN. § 420-G:11, G:11-a (2018); Josh Archambault & Nic Horton, *Right to Shop: The Next Big Thing in Health Care*, FORBES (Aug. 5, 2016, 12:12 PM), <https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care>.

to require all non-HMO plans to cover out-of-network providers with rates that are lower than the state average.¹⁸ In order to implement Right to Shop laws, states and/or providers must first build comprehensive databases, such as APCDs, and implement shopping tools necessary to allow consumers to accurately and adequately shop between providers and services.

Restrictions on Surprise and/or Balance Billing

Other efforts to improve price transparency focus on providing patients access to prices when they seek care and protecting them from surprise bills. When an insured patient sees an out-of-network provider, the provider can bill the patient for the difference between the provider's charges and the insurer's payment. These surprise or balance billing practices can result in astronomical out-of-pocket costs for patients, as Peter Drier of New York found out when he got the bill for \$117,000 from the assistant surgeon that he never met. These practices often affect patients in their weakest moments when they have little control over their care (e.g., in a hospital where they receive care from an out-of-network doctor at an in-network facility). In response, states have begun taking action to restrict surprise and balance billing.

Currently 24 states offer some protection from balance billing, but only less than half offer comprehensive safeguards.¹⁹ While some states, including Florida,²⁰ California,²¹ and, more recently, New Jersey,²² ban balance billing altogether, many states instead require some form of disclosure of potential balance or surprise billing. States have done this in different ways. For example, some states require providers to disclose that a patient might receive a bill

¹⁸ L.D. 445, 128th Leg., Reg. Sess. (Me. 2018).

¹⁹ See footnote 6. According to Lucia 2017, some states prohibit provider balance billing, while others require insurers to hold enrollees harmless from balance billing charges by paying the entire charge if necessary, and some do both. In states that have adopted both approaches, out-of-network providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays. In addition, insurers must guarantee that the consumer is held harmless from, and is not liable for, balance billing charges.

²⁰ H.B. 221, Reg. Sess. (Fla. 2016).

²¹ A.B. 72, Reg. Sess. (Cal. 2018).

²² A.B. 2039, Reg. Sess. (N.J. 2018).

for charges from out-of-network providers or that certain types of providers are not employed by the facility. For example, Tennessee requires health facilities to have patients sign the following statement before receiving care: “Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by this facility... Before receiving services, the patient should check with his or her insurance carrier to find out if the patient’s providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.”²³ These type of disclosure laws, however, do little more than cover the providers from liability, as patients often have little choice of emergency room physician or anesthesiologist. Without adequate information and viable options, patients have little ability to plan for or avoid such costs. The goal of price transparency initiatives is to reduce expenditures by allowing patients to shop for higher value care. Patients will be unable to meaningfully shop for care if they cannot know the prices before getting that care, they do not have a choice in providers, or if they may be charged excessively high fees that they could not anticipate.

Some states require disclosure of cost estimates. Minnesota requires providers to give patients good faith estimates of the payment the provider has agreed to accept from the consumer’s health plan and to disclose any fees, including facility fees, that an insurer does not typically pay.²⁴ Some states have gone a bit further and passed “hold harmless laws.” For example, Colorado requires a provider to accept payment that is equal to the rate the insurer would pay to an in-network provider.²⁵ Colorado, however, does not prohibit providers from sending bills to patients who might not understand that they do not have a responsibility to pay

²³ H.B. 1935 & S.B. 1869, 110th Leg., Reg. Sess. (Tenn. 2018) (codified at TENN. CODE ANN. § 56-7-120 (2018)) requires written consent for both the charges and the out-of-network statement.

²⁴ Minnesota Senate Bill 3480, which recently passed, requires provider to provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees. S.F. 3480, 90th Leg., Reg. Sess. (Minn. 2018).

²⁵ S.B. 06-213, 65th Leg., 2nd Reg. Sess. (Colo. 2006).

those bills.²⁶ By prohibiting surprise billing practices and requiring providers and insurers to negotiate out-of-network rates, at least for emergency services, states can protect patients from financially devastating and unavoidable healthcare bills.

Prohibitions on Anti-Transparency Contract Provisions

States have also begun to prohibit insurers and providers from including certain types of provisions in their contracts that might prevent disclosure of healthcare prices or price shopping. First, non-disclosure provisions, also known as “gag clauses,” often prohibit providers and insurers from disclosing negotiated prices, methods of cost-sharing, or more affordable treatment options. In 2017, Maine passed a law prohibiting gag clauses in pharmacy contracts, which states “if information related to an enrollee’s out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication is available to a pharmacy provider, a carrier or pharmacy benefits manager may not penalize a pharmacy provider for providing that information to an enrollee.”²⁷ In other instances, higher-priced providers have used anti-tiering or anti-steering contract provisions to prevent insurers from incentivizing patients to choose lower-cost providers. For example, insurers could signal which providers offer higher value care through the use of “tiered networks” by offering lower copays or other cost-sharing reductions to patients who use providers in preferred tiers. Most famously, North Carolina and the Department of Justice recently sued the Carolinas HealthCare System in an antitrust suit, claiming that the provider’s anti-tiering and anti-steering provisions violated Section 1 of the Sherman Act.²⁸ California is currently considering a bill to ban these contract provisions, but it has not yet passed.²⁹

²⁶ Lucia, *supra* note 6.

²⁷ L.D. 6, 128th Leg., Reg. Sess. (Me. 2017) (codified at ME. REV. STAT. ANN. tit. 24-a, § 4317 (2018)).

²⁸ *United States and the State of North Carolina v. The Charlotte-Mecklenburg Hosp. Auth., d/b/a Carolinas Healthcare System*, 248 F. Supp. 3d 720 (W.D.N.C. 2017). *See also United States v. Am. Express Co.*, 838 F.3d 179 (2d Cir. 2016).

²⁹ S.B. 538, Reg. Sess. (Cal. 2018).

Naming and Shaming Laws

In contrast to transparency laws that encourage or enable patients to make more cost-effective decisions about healthcare, laws that publicly display and/or fine entities with high healthcare prices aim to alert the public as to which entities are charging the highest prices and potentially shame them into lowering prices. In “naming and shaming laws,” states may also explicitly define price gouging, often saying if prices increase higher than some threshold without a reasonable justification, the state Attorney General can prosecute the entity for price gouging. In 2018, most naming and shaming laws focused on addressing drug prices; however, states could apply similar laws to non-pharmaceutical healthcare services in the future.

The states have demonstrated a keen interest in addressing healthcare costs and promoting healthcare price transparency. State laws have evolved over time to better satisfy consumer and governmental needs to access healthcare pricing data, yet there is still a long way to go.

The Unrealized Potential of Consumer-Focused Transparency Tools

With all the interest in state price transparency initiatives, one would think they had been quite successful at lowering healthcare spending. Despite growing efforts at both the state and federal level to increase transparency as a means of facilitating price shopping, so far these tools have been ineffective at substantially reducing costs. Studies examining these tools repeatedly demonstrate that simply offering patients access to price transparency tools alone has little effect on healthcare spending.^{30, 31, 32}

³⁰ Ethan M.J. Lieber, *Does It Pay to Know Prices in Health Care?*, 9 AM. ECON. J.: ECON. POL’Y 1, 154-79 (2017).

³¹ Sunita Desai et al., *Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, 36 HEALTH AFFAIRS 8, 1401-7 (2017).

³² Anna D. Sinaiko et al., *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 JAMA Internal Medicine 12, 1868-70 (2016).

Initially, price transparency tools offered patients provider retail rates, known as “chargemaster” rates. These provide little utility for insured patients attempting to know their out-of-pocket costs for a particular procedure by a particular provider within their particular plan. Patients also found the information on these websites confusing, as the terms and procedures were not standardized, the billing mechanisms were highly complex, and the prices often were broken out across a range of providers, services, and devices, making it impossible for a patient to fully anticipate his or her costs. Not surprisingly, consumers did not use these tools very often.

Over time, states and insurers offering consumer-facing price comparison tools, like NH Health Costs or United Healthcare’s MyUHC Cost Estimator,³³ began to offer consumers information on their out-of-pocket prices that were patient, provider, procedure, and plan specific. For a price transparency tool to be useful for consumers, it must tell them how different choices of providers will affect *their* costs. When a patient uses a price transparency tool, studies have typically found savings between 10 and 17% for that patient.^{34, 35} These results are promising, but research demonstrates that the effect on overall spending is minimal due to lack of consumer engagement with these tools.

Overwhelmingly, studies reveal patients’ reluctance to use price transparency tools when shopping for medical procedures, with approximately 2-20% of patients using available tools to

³³ *MyUHC Cost Estimator*, UNITED HEALTHCARE, <https://www.uhc.com/individual-and-family/member-resources/health-care-tools/cost-estimator>. (last visited July 14, 2018).

³⁴ Lieber, *supra* note 31.

³⁵ C. Whaley et al., *Association Between Availability of Health Service Prices and Payments for these Services*, 312 *JAMA* 16, 1679-76 (2014).

search for price information, depending on the intervention.^{36, 37, 38, 39, 40} For example, in a 2016 study, only 3.5% of Aetna enrollees used an available online, personalized, episode-level price comparison tool, but costs for enrollees that used the tool to search for diagnostic services were 12% less than those who did not use the tool.⁴¹ Further, a study by Desai et al. showed that access to a price transparency website led to only a 1% decrease in medical spending because less than 10% of eligible patients even logged into the online tool to search for any procedure or provider.⁴² Mehrotra et al. attempted to understand how patients seek out price information by interviewing 3,000 non-elderly Americans with recent out-of-pocket spending on medical services.⁴³ The researchers found that 13% of the interviewees had searched for price information before their care, but in most cases the patients had only called their physician or plan to determine their out-of-pocket costs, rather than use the online tool to compare prices and select a provider. Specifically, only 3% of the interviewed patients compared prices between different providers. Because so few patients use these tools, consumer-focused price transparency tools, even those that can provide provider specific and plan specific information, have generally demonstrated minimal savings.⁴⁴

The question is: why aren't these tools more widely used? First, most insurance benefit designs do not incentivize patients to shop for costs. For example, if a patient has a flat copay,

³⁶ Lieber, *supra* note 31.

³⁷ Whaley et al., *supra* note 36, at 1670-76.

³⁸ Anna D. Sinaiko & Meredith B. Rosenthal, *Examining a Healthcare Price Transparency Tool: Who Uses It, and How They Shop for Care*, 35 HEALTH AFFAIRS 4, 662-70 (2016).

³⁹ Desai et al., *supra* note 32.

⁴⁰ A. Mehrotra et al., *Americans Support Price Shopping for Health Care, but Few Actually Seek Out Price Information*, 36 HEALTH AFFAIRS 8, 1392-400 (2017).

⁴¹ Sinaiko et al., *supra* note 33.

⁴² Desai et al., *supra* note 10.

⁴³ Mehrotra et al., *supra* note 41.

⁴⁴ Mehrotra et al., *supra* note 9, at 1348-54.

she has little financial incentive to search for a cheaper provider.⁴⁵ Second, decisions about medical care are critically important and patients are often forced to make these decisions at particularly vulnerable and challenging times. Patients often simply do not have the stamina and energy to track down different provider prices, identify those with the lowest cost rates, make numerous phone calls to see which ones are actually taking patients and still remain in their network, and then wait for their appointment. They would much prefer to receive a short list of providers recommended by their primary care doctor or loved one and seek treatment from them. Finally, since patients have so much at stake, price is often not the determining factor when making medical decisions. For shoppable services, i.e., non-urgent and interchangeable services like laboratory or diagnostic tests, patients are more willing to shop based on price, but patients are much less likely to do so for services where the quality is harder to assess, like provider selection. Detailed interviews with patients with access to the Castlight price transparency tool⁴⁶ highlighted that factors other than price are most important when choosing a provider; patients described how their relationship, trust, and loyalty to their current providers was more important than cost.⁴⁷ Patients also face significant switching costs associated with becoming a patient at a new practice, including long wait times for appointments, additional paperwork, having to recount their medical history, and loss of provider knowledge about the patient's personal and medical history. As a result, the most opportune time to offer information about costs and value to patients is when they choose new insurance coverage or new providers.

All these factors mean that healthcare services differ substantially from most other items individuals purchase. Choosing to compare prices and change providers is not like choosing to

⁴⁵ Lieber, *supra* note 31.

⁴⁶ CASTLIGHT HEALTH, <https://www.castlighthealth.com/> (last visited July 14, 2018).

⁴⁷ H.L. Semigran et al., *Patients' Views on Price Shopping and Price Transparency*, 23 AM. J. OF MANAGED CARE 6, e186-92 (2017).

shop at a different car dealership or department store. The consequences of choosing a lower quality provider can be catastrophic and patients are often hesitant to shop for a better price, especially when making these choices without guidance and support. Furthermore, the lasting relationship patients often have with their primary care provider builds trust, and if their provider refers them to a particular specialist, patients often choose to see that particular provider without considering cost. Even individuals with high-deductible health plans (HDHPs), who seemingly have the highest financial incentives to shop for higher-value, lower-cost services, rarely switch providers or seek out lower-cost services. A study of people in the first two years of coverage under an HDHP found a 15% reduction on spending for healthcare services for these individuals.⁴⁸ Detailed economic analysis, however, showed that nearly all the savings came from reducing the amount of care the individuals received, not from price shopping or switching providers.⁴⁹

Collectively, these studies provide evidence that, when used effectively, price transparency tools can reduce the cost of health services. These studies also show, however, that to broaden the use and impact of these tools, we need to do more than simply provide patients with access to lists of providers and prices. We must engage other actors in healthcare markets by providing them access to relevant healthcare pricing information at critical decision-making points.

Maximizing the Potential of Price Transparency Tools

The current lack of price transparency in healthcare not only confounds patient decision-making, it also hinders provider treatment decisions, payer price setting, and governmental

⁴⁸ Zarek C. Brot-Goldberg et al., *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE Q. J. OF ECON. 3, 1261-1318 (2017).

⁴⁹ *Id.*

reform efforts and policy analysis. This section provides suggestions for how various price transparency initiatives can promote more cost effective decision-making and help bend the cost curve by providing patients, providers, payers, and policymakers essential information at critical decision points.

Patients

To maximize the effectiveness of consumer-facing price transparency tools, patients need actionable information from trusted sources and incentives to act on that information. For example, a study by Wu et al. demonstrated that when a representative of their insurer called patients, informed them about a lower-cost location for their MRI, and, if desired, helped reschedule their appointment at a high-value provider, the average cost for an MRIs decreased by 18.7% as patients shifted away from more expensive hospital-based facilities.⁵⁰ Furthermore, the authors found that prices at hospital-based facilities dropped over 10% and price variation in the metropolitan regions studied decreased by 30%, indicating that price transparency also encouraged providers to lower their price to remain competitive.⁵¹ Perhaps most encouragingly, the authors found that all patients in these areas experienced the benefits of lowered prices through competition.⁵² Entire communities benefit when the market encourages high-cost providers to lower their prices or justify higher prices with higher quality for their services.

Reference pricing provides another means of encouraging patients to use price transparency tools. When using reference pricing, an employer or insurer pays up to an established maximum price, the reference price, for a healthcare service. The reference price is typically set at a level that allows patients to receive a healthcare service from multiple high-

⁵⁰ S.J. Wu et al., *Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition*, 33 HEALTH AFFAIRS 8, 1391-98 (2015).

⁵¹ *Id.* The intervention was implemented in Atlanta, GA; Cincinnati, OH; Cleveland, OH; Indianapolis, IN; and St. Louis, MO.

⁵² *Id.*

quality providers without additional contribution. The patient must pay for any costs of the service above that price, so reference pricing encourages patients to be more engaged consumers. For instance, if the reference price for an office visit to a provider is \$200, the patient will receive full coverage for providers that charge \$200 or less, but they will need to pay \$50 extra for a provider that charges \$250. Unlike HDHPs, where patients might be forced to forgo care if they cannot afford the procedure, reference pricing lowers costs while ensuring that patients can access care from a range of covered providers.

Reference pricing thus preserves a patient's ability to choose higher-priced providers if she values their services enough to pay the higher rate, and simultaneously encourages providers to drop their price to the reference price. A study by Robinson and Brown found that price transparency tools coupled with reference pricing effectively directed patients seeking orthopedic surgery to lower-cost providers and, similarly to the study by Wu et al., the costs of the procedure at high-priced facilities decreased by 30% due to price competition.⁵³ Studies of two of the leaders in adopting reference pricing, the California Public Employees' Retirement System (CalPERS) and the grocery firm Safeway, demonstrate the potential of coupling reference pricing and consumer price shopping. These organizations reduced spending by 20% for joint replacement,⁵⁴ 18% for cataract removal,⁵⁵ 21% for colonoscopy,⁵⁶ 17% for arthroscopy,⁵⁷ 12%

⁵³ J.C. Robinson & T.T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 33 HEALTH AFFAIRS 8, 1392-97 (2013).

⁵⁴ *Id.*

⁵⁵ J.C. Robinson et al., *Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery*, 34 HEALTH AFFAIRS, 415-22 (2015).

⁵⁶ J.C. Robinson et al., *Association of Reference Payment for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications*, 175 JAMA INTERNAL MEDICINE, 1783-89 (2015).

⁵⁷ J.C. Robinson et al., *Consumer Choice Between Hospital-Based and Freestanding Facilities for Arthroscopy: Impact on Prices, Spending, and Surgical Complications*, 97 THE J. OF BONE AND JOINT SURGERY, 1473-81 (2015).

for computed tomography,⁵⁸ and 32% for laboratory assays⁵⁹ using reference pricing. Montana also used reference pricing to control healthcare costs for beneficiaries in the state employees' health plan⁶⁰ and agreed to pay an average of 234% of Medicare rates for hospital services.⁶¹ Since the program started in July 2016, the state has saved \$15.6 million⁶² and will save an estimated \$25 million by the end of 2018.⁶³ A study by researchers at the University of California, Berkeley, estimated that if the insurers Aetna, United Healthcare, and Humana all implemented reference pricing for laboratory testing services for their commercially insured patients, collectively they would save \$7.6 billion annually, or about 8% of the total spending for this population.⁶⁴

Taken together, these studies demonstrate the potential of price transparency tools when coupled with other mechanisms to encourage their use. They further demonstrate the potential of price transparency between providers to leverage competitive forces to drive down prices. An important caveat, however, is that these studies focus on "shoppable" medical services, ones that are generally standardized and relatively interchangeable, like laboratory tests and generic drugs. In other words, they are not relationship-based services; they do not require patients to switch providers.

⁵⁸ J.C. Robinson et al., *Reference Pricing, Consumer Cost-Sharing, and Insurer Spending for Advanced Imaging Tests*, 54 MEDICAL CARE, 1050-1055 (2016).

⁵⁹ J.C. Robinson et al., *Association of Reference Pricing for Diagnostic Laboratory Testing with Changes in Patient Choices, Prices, and Total Spending for Diagnostic Tests*, 176 JAMA INTERNAL MEDICINE, 1353-59 (2016).

⁶⁰ Julie Appleby, *Holy Cow' Moment Changes How Montana's State Health Plan Does Business*, THE WASHINGTON POST (June 20, 2018), https://www.washingtonpost.com/national/health-science/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/2018/06/20/92b3693c-746a-11e8-bda1-18e53a448a14_story.html?utm_term=.df1a721650a1.

⁶¹ Appleby, *supra* note 60.

⁶² *Id.*

⁶³ Press Release, State of Montana Government, Governor Bullock Announces State Health Plan Change Will Save Taxpayers More Than \$25 Million By End of 2018 (July 8, 2016), <https://news.mt.gov/governor-bullock-announces-state-health-plan-change-will-save-taxpayers-more-than-25-million-by-end-of-2018>.

⁶⁴ J.C. Robinson et al., *Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers*, 3 HEALTH AFFAIRS, 524-30 (2017).

To bend the cost curve, however, patients need to choose lower-priced providers. As noted above, consumers have been more reluctant to use price transparency tools to select providers. Trust and relationships are paramount for most patients, especially sick ones. A survey of people with HDHP insurance coverage showed that, while the majority of these enrollees believed there were large differences in price between providers, and that higher-cost providers were not necessarily of higher quality, they were no more likely than enrollees in traditional plans to considering switching providers or to compare out of pocket costs for a new provider.⁶⁵ Simply put, patients are reluctant to switch providers, even when it might mean substantial out-of-pocket savings.

Furthermore, the burden of lowering healthcare costs should not be placed solely on the weakest and most vulnerable link in the healthcare chain, patients. Those who can most benefit from price transparency tools are often too sick and overwhelmed to appropriately advocate for themselves and navigate the complicated labyrinth of insurance networks, plan benefit design, and healthcare prices. The stakes are simply too high for individuals – one misstep could result in financial ruin, loss of a home, or bankruptcy. Other actors in the healthcare market, including providers, employers, insurers, and policymakers, should also leverage price transparency tools to lower costs.

Providers

Primary care providers are uniquely well-positioned to use price transparency tools to guide patients toward lower-cost providers when making decisions about which specialist to see and which treatment options to consider. Patients often want an informed referral or recommendation from a trusted provider that takes price into account. One survey of insured

⁶⁵ A.D. Sinaiko et al., *Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care Enrollees with Skin in the Game*. 176 JAMA INTERNAL MEDICINE 3, 395–97 (2016).

patients found that more than 80% wanted to discuss costs with their doctor, and 75% of patients reported they wanted their physician to consider out-of-pocket costs before making decisions for their care.⁶⁶ This kind of consultation between patient and provider reflects the most complete form of informed consent, known as shared decision-making, in which the provider and patient jointly consider all of the relevant information about a particular treatment decision – including the costs, risks, and benefits of various treatment options – and use that information to make a treatment choice that best reflects the patient’s preferences.⁶⁷ The same survey that demonstrated that patients want their doctors to consider costs found that less than half of the surveyed patients could find information about healthcare costs when needed.⁶⁸ Since primary care physicians occupy a sentinel role in connecting patients to other services, they can successfully steer patients to lower-cost facilities and providers, and offer guidance on lower-cost alternatives *if* they have access to a particular patient’s insurance network, pricing, and cost-sharing obligations when recommending treatment.

Implementation of this kind of sophisticated interaction, however, faces many challenges. Foremost among them is that providers need price information that is patient, procedure, provider, and plan specific at the time of decision-making, i.e., during a patient’s appointment. Few providers know what their patients will have to pay for the care they recommend. Currently, physicians often struggle to find out if a particular provider is in a patient’s insurance network at the time a referral is made, so developing tools that give providers the necessary detailed information through coordinated infrastructure and interoperability between electronic medical

⁶⁶ N.B. Henrikson et al., *Communication with Physicians about Health Care Costs: Survey of an Insured Population*, 21 THE PERMANENTE J. 2, 16–070 (2017).

⁶⁷ Jaime S. King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J. L. & MED. 429 (2006).

⁶⁸ Henrikson, *supra* note 66.

records (EMRs) and insurers will require substantial systematic changes. However, health systems, especially those with an insurance arm, have begun offering providers such information via EMRs, and data reporting practices to APCDs could help facilitate the integration of price and insurance information into EMRs. Even if EMRs could systematically incorporate patient insurance information, provider network lists and information on which providers currently accept new patients would need to be consistently updated to reflect accurate information, so that patients do not inadvertently seek treatment from an out-of-network provider. Further, the short duration of most physician visits, typically 15 minutes, limits the amount of time that can be spent on treatment choice and provider selection. Engaging a patient in a meaningful discussion about the potential risks and benefits, including financial risks and benefits, of different treatment options requires time, and providers should be paid for providing this service.

Payers

Payers for healthcare in the U.S., mostly insurers and employers, also have much to gain from increased price transparency. Approximately half of Americans receive their health insurance through their employer,⁶⁹ and as a main conduit to healthcare, employers have a strong incentive to steer their employees to high-value, lower-priced care. Employers provide health insurance to their employees by either selecting an insurance provider and contributing to premiums or by self-insuring their patients and paying directly for their care, often through a third-party administrator. When choosing an insurance plan, employers need information on the premiums, benefit design, breadth of the provider network, and the cost of services when employees must go outside of the network. When self-insuring, employers need data on the

⁶⁹ *Health Insurance Coverage of the Total Population*, KFF.ORG, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited July 14, 2018).

negotiated prices that health plans pay for a wide range of services to ensure they are obtaining reasonable rates. They also need information on the size of the provider network needed to ensure that patients can stay in-network for most care. Employers must have a sense of the range of rates for out-of-network care to predict their overall exposure. Having access to an APCD to analyze benchmarks for insurer negotiated rates would prove very helpful to employers seeking to self-insure their employees.

While insurers generally have access to the rates they negotiate with providers, they can also benefit from having access to benchmarks for insurer negotiated rates in a particular geographic area when negotiating their own rates. While making negotiated rates entirely transparent presents some risks of price collusion,⁷⁰ using claims data from an APCD to establish average pricing benchmarks for average to high quality providers should encourage, rather than threaten competition. Further, health plans can benefit from being able to encourage patients to select higher-value/lower-cost providers through tiering and reference pricing tools. Price transparency initiatives that prohibit anti-tiering/anti-steering contract provisions also can facilitate use of those tools.

Policymakers

Finally, policymakers probably have the most to gain from improved transparency of healthcare prices. As noted above, state governments have shown a great deal of interest in obtaining healthcare price data for a variety of uses. States can use healthcare claims data reported to an APCD to examine the drivers of healthcare costs over time, the effectiveness of various reform efforts, the impact of mergers, acquisitions, and other affiliations on healthcare price and quality, and other factors that might hinder competition and efficiency in the healthcare

⁷⁰ Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L. J. 55 (2016).

market. For example, Oregon recently published a report summarizing 54 use cases for its APCD, the Oregon All-Payer All-Claims Database.⁷¹ Identifying Oregon's APCD as "an integral component of the state's ongoing healthcare improvement efforts," the report outlined numerous uses for the APCD data in analyzing and monitoring healthcare spending and cost trends, healthcare delivery system performance, healthcare utilization, population health, disease prevention, and insurance coverage.⁷² Oregon, Colorado, and Maryland have used their APCD data to analyze geographic variations in price and utilization of healthcare services to detect unwarranted variations due to overutilization and market consolidation.⁷³ Massachusetts' APCD provides essential information to the Massachusetts Health Policy Commission to track healthcare spending trends and inform policy and legal decisions regarding consolidation and payment reform.⁷⁴ Finally, New York views its developing APCD, the NYS Connector, as a central hub of health information that will collect and synthesize all varieties of health data from the entire state. According to the New York Department of Health, "the APD [all payer database] is creating new capability within the Department, including more advanced and comprehensive analytics to support decision-making, policy development, and research, while enhancing data security by protecting patient privacy through encryption and de-identification of potentially identifying information."⁷⁵ Perhaps state health policy experts, Joel Ario and Kevin McAvey,

⁷¹ OREGON ALL-PAYER ALL-CLAIMS DATABASE USE CASE DOCUMENT (2017), <https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Use-Cases.pdf>.

⁷² *Id.*

⁷³ A. COSTELLO ET AL., APCD COUNCIL, INFORMING HEALTH SYSTEMS CHANGE - USE OF ALL-PAYER CLAIMS DATABASES (2018), <https://www.apcdcouncil.org/publication/informing-health-system-change-use-all-payer-claims-databases>.

⁷⁴ *Massachusetts Health Policy Commission*, MASS.GOV, <https://www.mass.gov/orgs/massachusetts-health-policy-commission> (last visited July 14, 2018).

⁷⁵ *New York State All Payer Database*, HEALTH.NY.GOV, https://www.health.ny.gov/technology/all_payer_database/ (last visited July 14, 2018).

said it best in their recent Health Affairs Blog post, “APCDs are very much a work in progress, with tremendous unrealized potential.”⁷⁶

Legal Barriers to Price Transparency

Yet a range of laws and contractual provisions currently hinder the potential of APCDs and other price transparency initiatives. Many states currently lack access to a complete set of claims data in their APCDs because federal laws, trade secret protections, and contract provisions limit what data they can demand from insurers. First and foremost, the Federal Employee Retirement Income Security Act of 1974 (ERISA) preempts any state law that “relates to an employee benefit plan.”⁷⁷ ERISA’s preemptive reach is limited by the “savings clause” which saves all laws that regulate insurance from preemption,⁷⁸ but ERISA does not deem self-insured employer plans to constitute insurance for purposes of regulation. Therefore, ERISA preempts any state insurance law that relates to an employee benefit plan provided by a self-insured employer.⁷⁹ Consequently, many state transparency laws that target health plans do not apply to self-insured employers’ plans, including laws requiring reporting or disclosure of healthcare claims data, drug pricing methodologies, provider network status, and billing information.

Most crippling, in 2015, the Supreme Court in *Gobeille v. Liberty Mutual Insurance Co.* held that ERISA preempts state APCD reporting requirements with respect to self-insured employer health benefit plans.⁸⁰ Specifically, self-insured employers and their third party

⁷⁶ Ario & McAvey, *supra* note 13.

⁷⁷ ERISA § 514(a) (1974); 29 U.S.C. § 1144(a) (2006).

⁷⁸ *Kentucky Ass’n of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003). The savings clause will save state insurance regulations from preemption so long as they are “specifically directed at entities engaged in insurance,” and the state law “substantially affect[s] the risk pooling arrangement between the insurer and the insured.”

⁷⁹ 29 U.S.C. § 1144(b)(2)(B) (2006).

⁸⁰ *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2015).

administrators, which cover approximately two-thirds of all workers with employer-based health insurance, are exempt from submitting their claims data to the APCD, significantly limiting the number of plans that must report to the APCD and the percentage of employee claims data included in the database. As such, the loss of self-insured employees' claims data deprives state APCDs from having the essential information needed to provide robust analysis on healthcare cost, quality, utilization, and geographic variations within the state.

Second, as noted above, providers and insurers often include specific provisions in their contracts designed to keep healthcare prices secret, such as "gag clauses" or anti-tiering/anti-steering provisions. These types of contract provisions greatly hinder patients' ability to choose high-value services, and policymakers' ability to know and understand how to best reform the healthcare system. States have passed laws prohibiting these and other similar provisions in provider-insurer contracts, but the impact of these laws has been limited due to claims that negotiated healthcare prices constitute trade secrets.

Third, providers and insurers have successfully used trade secrets protections to prevent disclosure of negotiated healthcare price information in the absence of the contract provisions above. Historically, the states have governed trade secret laws, but Congress passed the federal Defend Trade Secrets Act of 2016 (DTSA) to establish a floor for trade secrets protection. The DTSA allows businesses and individuals to keep information confidential if 1) "the owner has taken reasonable measures to keep such information secret"; and 2) "the information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable through proper means by, another person who can obtain economic value from the disclosure or use of the information."⁸¹ Some states, like California, Illinois, and

⁸¹ The Defend Trade Secrets Act, 18 U.S.C.A. § 1839(3) (2016).

Oregon have broader protections of trade secrets that would enable more information to constitute a trade secret.

Historically, courts did not consider prices eligible for trade secret protections, but in our modern economy where business-to-business transactions are more common, this question is not so straightforward. Many healthcare organizations now claim trade secrets protections to avoid disclosure of their negotiated prices, rebates, discounts, and other pricing information. This jealous guarding of prices compromises the decision-making of nearly every stakeholder in the healthcare market and contributes significantly to the ever-rising price of healthcare goods and services. Ironically, no court has affirmatively decided that negotiated healthcare prices constitute a trade secret.⁸² Trade secret cases are highly fact specific, such that even if a court found in a particular case that the confidentiality of such prices should be protected, it would not be generalizable to other cases. Yet, the mere claim that negotiated price information constitutes a trade secret has seemingly been sufficient to stop many who seek the data from continuing to do so or taking the issue to court, allowing provider and insurer organizations to use legal protections to avoid disclosure of information that has the potential to lower their revenues.

Ultimately, ERISA, contract provisions, and trade secret laws form a formidable obstruction to price transparency in healthcare that require federal intervention.

What Can Congress Do?

For transparency initiatives to achieve their full effect at the state level, the federal government must make changes. Despite the need for federal policy to maximize healthcare

⁸² A number of courts have discussed how negotiated price lists may be considered trade secrets, but none have ruled squarely on the issue. *See, e.g., Synthes, Inc. v. Emerge Med., Inc.*, 25 F. Supp. 3d 617, 706 (E.D. Pa. 2014), *In re Maxim Med. Grp., Inc.*, 434 B.R. 660, 669 (Bankr. M.D. Fla. 2010), *Emergency Care Research Inst. v. Guidant Corp.*, No. CIV.A. 06-1898, 2007 WL 2702455, at *5 (E.D. Pa. Sept. 12, 2007) and *Emergency Care Research Inst. v. Guidant Corp.*, No. 06-1898, 2006 WL 3541776, at *3 (E.D. Pa. Dec. 5, 2006).

transparency efforts, policymakers should craft changes to preserve state flexibility and innovation. Fortunately, Congress, more than any other entity, has the ability to address the most significant barriers to price transparency in healthcare and maximize the tremendous untapped potential of existing state initiatives, in particular APCDs.

1. Address ERISA Preemption Challenges

APCDs have the greatest potential of any price transparency initiative to inform consumers and policymakers in ways that can help control healthcare costs. Unfortunately, following the *Gobeille* decision to allow ERISA preemption of state APCD reporting requirements as applied to self-insured employer plans, many data reporters have reduced or ceased their submission of healthcare claims data to state APCDs, depriving state governments, researchers, and the public from access to essential information on healthcare costs, quality, and utilization.⁸³

The omission of self-insured employer claims data greatly limits the accuracy and utility of APCDs. Essentially for health policy analysts, trying to analyze the healthcare landscape using an APCD without the self-insured employer population is akin to trying to use GoogleMaps with one-third of the roads missing – you don’t have the whole picture. Enabling APCDs to collect the full set of healthcare claims data would dramatically increase the utility and reliability of these initiatives.

Congress can pursue several paths to relieving the burden of ERISA preemption on APCDs. It could pass legislation creating a federal APCD that required reporting on all claims from all healthcare payers. While a federal APCD would standardize reporting requirements,

⁸³ See NATIONAL ACADEMY FOR STATE HEALTH POLICY, COMMENTS ON DEPARTMENT OF LABOR NOTICE OF PROPOSED RULEMAKING 1 (2016), <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB63/00030.pdf>.

streamline, and simplify reporting mechanisms, and create one complete dataset for the entire country, such an initiative would further entrench the federal government's role in healthcare and require significant human and capital resources. A federal APCD would also fail to capitalize on the investment made by nearly half the states to develop state APCDs.

Rather than reinvent the wheel, Congress should invest its efforts in facilitating the already significant strides made by state APCDs. The most effective and direct manner of doing so would be to amend ERISA to narrow preemption to exclude state health regulations that do not unduly burden ERISA's goal of uniformity for employer-based benefit plans, while also granting states sufficient flexibility to achieve their health reform goals.⁸⁴ Amending ERISA's preemption scheme to replace broad preemption with conflict preemption would permit the states to experiment with a variety of health reform proposals, including price transparency initiatives, while permitting ERISA to preempt any state law that directly conflicts with the federal law.⁸⁵

Alternatively, Congress could pass legislation that affirms the Department of Labor's authority to collect healthcare claims data from ERISA plans and allow them to partner with state APCDs under ERISA § 506, such that the Department of Labor could require ERISA plans to submit claims data to state APCDs.⁸⁶ For states that have not yet created an APCD, the Department could require ERISA plans to submit claims data to a third party contracted to perform the APCD functions for those states, similar to the federal marketplace created by the Patient Protection and Affordable Care Act of 2010. The Department of Labor could facilitate

⁸⁴ Erin C. Fuse Brown & Jaime S. King, *ERISA as a Barrier for State Health Care Transparency Efforts*, TRANSPARENCY IN HEALTH AND HEALTH CARE (Holly Fernandez Lynch, I. Glenn Cohen, & Barbara Evans eds., Cambridge University Press, forthcoming 2019) (manuscript at 10-11), <https://ssrn.com/abstract=3214173>.

⁸⁵ Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 103 (2016); Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 N. Eng. J. Med. 5, 7 (2018).

⁸⁶ 29 U.S.C. § 1136 (1996).

the collection of this additional claims data with minimal financial investment and also develop the ability to request reports from the state APCDs on claim information from employee benefit plans.⁸⁷ On the other hand, this approach would leave ERISA's broader preemption scheme in place, which would still hinder other state transparency initiatives like surprise billing protections, pharmacy benefit transparency laws, and anti-tiering and anti-steering prohibitions, making a direct amendment of ERISA the preferred approach for promoting price transparency initiatives overall.

Under either approach, Congress should require that state APCDs request claims data in a standardized manner to minimize the burden for multi-state employers and to facilitate data comparisons across states. State APCDs have already developed and agreed upon a standardized set of healthcare claim and related data that can be collected from all health plans – the Common Data Layout.⁸⁸ The Common Data Layout creates a uniform system of reporting across all state APCDs that will ease the reporting burden on employers, third-party administrators, and insurance companies, satisfy ERISA's uniformity requirements, and facilitates analysis of claims data across states. Further, the depth of information reported in the Common Data Layout could strengthen the Department of Labor's ability to monitor ERISA plans well beyond any information the Department currently collects.

Overall, addressing ERISA preemption of state health reform laws is *the* most important action Congress could take at this time to promote price transparency to bring down healthcare costs, but additional actions by Congress could also further illuminate healthcare prices.

⁸⁷ See Fuse Brown & King, *supra* note 84, at 8-9.

⁸⁸ See NATIONAL ACADEMY FOR STATE HEALTH POLICY, COMMENTS ON DEPARTMENT OF LABOR NOTICE OF PROPOSED RULEMAKING (2016), <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB63/00030.pdf>.

2. Encourage Consumer Pricing Shopping Initiatives

Congress should seek to encourage consumer price shopping initiatives like reference pricing, rewards, and tiered networks to provide patients with further incentives to select high-value/lower-priced providers. Congress could promote reference pricing by implementing reference pricing schemes into Medicare and funding pilot projects to test reference pricing in a variety of settings. Congress could also facilitate insurers' attempts to signal lower-priced providers to patients by prohibiting anti-tiering/anti-steering provisions in contracts or prohibiting them in ERISA plan contracts.

3. Create a Public Interest Exemption to Trade Secrets

Trade secrets protections were designed to encourage and protect innovation, not protect exorbitant prices that take advantage of consumers, bankrupt businesses, and bleed government coffers. Congress should pass a public interest exemption to the Defend Trade Secrets Act of 2016 that clearly establishes that trade secret protections will not apply to information being kept secret in ways that harm the public's interest. In the case of negotiated healthcare prices, keeping negotiated rates secret from competitors in highly concentrated markets where disclosure might drive costs up might serve the public interest, but keeping those same rates secret from the government, employers who pay them, or consumers would not. Evaluation of this standard would be a highly fact-specific analysis, performed on a case by case basis, yet it would provide a clear opportunity to better define the specific contours of trade secret protections in healthcare and raise questions about whether trade secrets protections apply to all or any negotiated healthcare prices.

4. Mandate Interoperability of Electronic Medical Records Systems

Similar to the Common Data Layout, Congress should require manufacturers of electronic medical records and insurance companies to establish uniform standards of interoperability and data reporting practices, such that a patient's insurance information can load into a provider's electronic medical record to enable the provider to access meaningful network, out-of-pocket cost, and quality information for patients when making provider and medical service referrals during appointments. Placing relevant cost information into the hands of both patients and providers when they are selecting a treatment or provider will significantly increase the odds that patients will incorporate such information into their healthcare choices.

5. Develop Billing Codes to Pay for Physician Time for Shared Decision-Making

Congress should develop billing codes and other payment mechanisms within Medicare to pay for physician time in discussing treatment selection, including information on which providers are "in-network" and what the cost to the patient would be of different treatment choices. Shared decision-making that includes a discussion of the out-of-pocket costs to the patient not only encourages physicians to provide a robust form of informed consent to patients, but it also has the added benefits of encouraging patients to shop for healthcare services and potentially decreasing overutilization of services that patients would not choose if they knew all the risks and benefits.

Thank you for your time and your consideration of these important issues.

APPENDIX A

2018 Legislative Session

During the 2018 legislative session, state legislatures have attempted to pass laws related to healthcare price and quality transparency. In 2018 the legislatures have focused particularly on lowering drug prices, and as such, have constructed their legislation to target drug manufacturers, pharmacy benefits managers (PBMs), formularies, and other pharmaceutical-related entities and tools. The vast majority of these bills target consumers' access to healthcare price and quality information, rather than other stakeholders.

<u>Focus of Bill*</u>	<u>Number of Bills Introduced in 2018**</u>	<u>Number Passed in 2018**</u>	<u>Number Died in 2018**</u>
<u>Pharmacy Gag Clauses, Clawback Prohibitions, and Mandatory Disclosure of Cheaper Drug Alternatives</u>	55	25	17
<u>Price Comparison (Right to Shop, the Right to Know, and Transparency Website/Tools)</u>	46	5	23
<u>Prohibition on Price Gouging</u>	43	2	21

(Continued on next page)

<u>Focus of Bill*</u>	<u>Number of Bills Introduced in 2018**</u>	<u>Number Passed in 2018**</u>	<u>Number Died in 2018**</u>
<u>"Pricing Report" Laws</u> <u>(Mandatory Disclosure of Drug</u> <u>Prices, Increase in Costs, or</u> <u>Pricing Mechanisms)</u>	41	8	16
<u>Surprise and/or Balance Billing</u> <u>Laws</u>	34	7	15
<u>All Payer Claims Databases</u> <u>(APCD)</u>	9	2	4
<u>Reference Pricing Laws</u>	8	2	4
<u>Chargemaster Laws</u>	4	0	3
<u>Price/Claim Request</u>	3	0	3

* Some categories of transparency bills not included in this summary as there are too few bills or do not specifically target price/quality, though they may impact either.

** All data as of July 3, 2018.

Mr. HARPER. Thank you very much, Dr. King.

And the chair will now recognize Dr. Chernew for 5 minutes for purposes of his opening statement.

STATEMENT OF MICHAEL CHERNEW

Mr. CHERNEW. Thank you very much, Chairman Harper, Ranking Member DeGette, members and staff. Thank you for the opportunity to speak with you today about price transparency in healthcare.

Before I launch into the main thrust of my comments I would like to emphasize that as an economist I believe strongly in markets. Well-functioning markets require buyers to effectively shop for the combination of price and quality that best meets their needs. And in the market for medical services, buyers, in this case patients, do not have the necessary information.

For that reason, one would think that efforts to promote price transparency in healthcare would be able to significantly lower the cost and perhaps improve the quality of care. In fact, this logic has spawned the creation of numerous transparency initiatives and tools, launched several innovative companies. All of the major insurers that I'm aware of have some price transparency tools—not all are great—as do many other vendors in several states who are pursuing transparency-related programs.

Although there are a few studies that suggest transparency initiatives may be helpful, such as the one in New Hampshire, they've only had a modest impact on the spending for some services, at best. Overall, the evidence, unfortunately, suggests that the impact of transparency has been minimal.

This reflects several institutional features of healthcare. First, healthcare is complex. Any course of treatment or diagnostic pathway is comprised of many individual services. An accurate price quote requires knowing the exact service. This is complex.

For example, there are over 50 codes for CT scans. In some cases it is even unknowable because the exact service delivered may change during the course of treatment based on clinical information that arises during that treatment. Moreover, the fees to the hospital and the physician are often separate. To get an accurate price, they have to be combined. This makes it hard, particularly for providers, to provide the information.

Imagine when shopping for a car consumers could only get the average price of a specific car, and that the actual price that they would pay depended on who put them together and the customer's employer. The information would be of limited value.

Most transparency tools seek ways around this, but so far there have not been great successes.

Second, physicians are central to almost all consequential decisions in healthcare. Physician recommendations about where to seek care appropriately carry enormous weight. As a result, few patients shop for care. In our work, we find around 10 to 15 percent of patients use transparency tools when offered. This result seems pretty standard in the literature. While it's certainly true that patients can question or even ignore their physician's referral recommendations, few do.

Third, consolidation in healthcare markets limits choice and, thus, competition in some markets. Specifically, competitive forces can only work when there are competing firms. As markets have consolidated, the potential for transparency or shopping more broadly diminishes.

Finally, insurance distorts choices. Patients fundamentally care about what they pay out of pocket. The out-of-pocket price will depend on the details of the patient's insurance plan and will change over time depending on things like whether they've met their deductible. As a result, one cannot accurately quote an out-of-pocket price without knowing details about the patient's health plan and how much they've often already spent, often for specific services. This implies that insurers are best suited to provide transparency information and, as noted, many do, although, as we've mentioned, with relatively little impact.

I do not mean to imply that transparency, or more generally price shopping for medical services, cannot work. Very simplified indicators such as flagging high-priced providers, as happened in some tiered insurance products can help, particularly when tied to benefit design. Moreover, transparency can have an impact even if it does not alter consumer behavior. The widespread availability of data may shame high-priced providers to lower their prices, particularly when journalists have access.

There's some evidence that this can be salient in healthcare. However, one has to proceed with caution, caution because it's also possible that widespread availability of information could alter the negotiation dynamics in other ways, leading to higher prices for some patients. Because payers negotiate price discounts with providers, if forced to reveal those discounts the providers may be more reticent to offer them. And there's some evidence of that in markets outside of healthcare.

So, where does this leave us? I'm generally supportive of the initiatives, particularly the private sector ones that simplify the information and focus on out-of-pocket prices. I'm more skeptical about public sector initiatives that entail new mandates on providers to provide data because it's particularly hard to get that data right. I worry it will not substantially improve the system, and may impose administrative costs.

There is certainly a lot we do not know. And while there may be deleterious unintended consequences, most evidence is either neutral or positive, and I think the shaming effect may be important in the most egregious cases. Moreover, states are experimenting in many ways, which should be allowed to play out.

So, there are a few fundamental things the Federal Government could support those efforts.

The first, as was mentioned, support the ERISA exemption or get rid of the ERISA exemption.

Providing financial support for All Payer Claims Databases could be a wise investment.

And providing more funding to AHRQ or other federal agencies to study what is actually working.

We have a lot of problems in healthcare, and I very much applaud your efforts to seek a solution. But please do not let transparency distract you from other strategies such as supporting alter-

native payment models or addressing adverse selection in the individual markets of healthcare that may be more impactful.

Thank you.

[The prepared statement of Mr. Chernew follows:]

Testimony of:

Michael Chernew

Examining State Efforts to Improve Transparency in Health Care Costs for Consumers

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

U.S. House of Representatives

Tuesday, July 17, 2018

Main points

- Well-functioning markets require well informed consumers.
- Consumers in health care markets are poorly informed and health care markets do not function well.
- It is logical therefore to assume that improving information in health care markets would support lower prices and better quality
- However, evidence suggests transparency initiatives that improve information in health care will not have a significant impact, though there are some clinical areas (e.g., imaging) where research is more positive. The reason for the limited broad impact is that other aspects of health care markets limit their effectiveness
 - Health care services are purchased in very fragmented units
 - Patients defer to physicians
 - Some markets have too few providers to be considered competitive
 - Insurance masks true price differentials
- Nevertheless, policy makers can take some action to support greater competition, these include
 - Requiring ERISA plans to submit data to All Payer Claims Databases
 - Providing financial support to APCDs
- Funding greater research on competition and competitive strategies

Testimony

Chairman Harper, ranking minority member Degette, members and staff, thank you very much for the opportunity to speak with you today about price transparency in health care. I am going to confine my remarks to transparency in the context of medical services, excluding prescription drugs or insurance. This is only because the market for insurance is completely different than that for health care services and the prescription drug market has unique issues and complexities.

Before I launch into the main thrust of my comments, I would like to emphasize that as an economist I believe strongly in the merits of markets. Moreover, I suspect that you have asked me here today because you, correctly, recognize that markets for medical services are not working well. This is part because well-functioning markets require buyers to effectively shop for the combination of price and quality that best meets their needs and in the market for medical services buyers—in this case patients—do not have the necessary information.

Taken together, the logic outlined above would suggest that efforts to promote price transparency in health care would be able to significantly lower the cost, and perhaps improve the quality, of care. In fact, this logic has spawned the creation of numerous transparency initiatives and launched several innovative companies. All of the major insurers I am aware of have transparency tools, as do many other vendors and several states are pursuing transparency related programs. Although there are a few studies that suggest transparency initiatives, such as New Hampshire, can have a modest impact on spending for some services,¹ overall, the evidence, unfortunately, has not been kind to these initiatives. Many studies, including several of my own and those of my colleagues, find that transparency has minimal, if any impact on the market.² This reflects several institutional features of health care.

¹ <http://www.economics.illinois.edu/seminars/documents/Brown.Pdf>; Whaley C, Schneider Chafen J, Pinkard S, et al. Association between availability of health service prices and payments for these services. *JAMA*. 2014;312(16):1670-1676. doi: 10.1001/jama.2014.13373.

² Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA*. 2016;315(17):1874-1881.

First, health care is complex. Any course of treatment (or diagnostic pathway) is comprised of many individual services. For example, there are 10 codes for office visits and 56 for CT scans (based on the CPT code list CMS released in Nov 2017).³ If one wants to know the price of a service, one would need to specify the exact service and that is hard. In some cases, it is even unknowable because the exact service delivered may change during the course of a test or procedure based on clinical information that arises. Though this complexity can be minimized by reporting averages for broader service groups, many providers are often involved in care delivery and each has a different price. For example, a surgery will include different fees to the hospital and surgeon. The hospital will likely not know the surgeon's fee and the surgeon will not know the hospital fees.

I am aware of several website that support shopping for other important items such as cars. But imagine those websites could only provide data on specific parts and the customer had to know which were needed and how well they would work together. That would diminish, if not destroy the usefulness of such shopping tools. In addition to the complexity arising from the fragmented way in which we buy care, any given provider is paid a different amount from different insurers. In one study we found that large insurers paid 21% less than smaller ones.⁴ Therefore, to quote an accurate price, one must know the patient's insurer (and maybe even their exact health plan). All of this complexity makes seemingly simple goals, like requiring providers to post or provide accurate price quotes, difficult.

Second, the physicians are central to almost all consequential decisions in health care. Patients trust their physicians to guide them through the episode of care, laying out alternatives and recommending treatments. Physician recommendations about where to seek care carry enormous weight. As a result, few patients shop for care. In our work we find that around 10% to 15% percent

³ https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html

⁴ Roberts ET, Chernew ME, McWilliams JM. Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices. *HEALTH AFFAIRS* 36, NO. 1 (2017): 141–148

of patients used a transparency tool when offered.⁵ This result seems pretty standard in the literature.⁶ While it is certainly true that patients can question, or even ignore, their physician's referral recommendations, few do.

Third, consolidation in health care markets limits choice, and thus competition, in some markets. Specifically, competitive forces can only work when there are competing firms. Gaynor and colleagues (2015) report that between 1990 and 2006, the proportion of metropolitan statistical areas (MSAs) with "highly concentrated" hospital markets increased from 65 percent to 80 percent.⁷ Likewise, Capps and colleagues (2017) report that 22 percent of physician markets in 2013 were highly concentrated.⁸ Moreover, hospitals are increasingly buying physician practices further diminishing competition.⁹

Finally, insurance distorts choices. Some patients may care about the total price of care, but most fundamentally care about what they pay out of pocket. Often insurance masks the true cost of care because patients pay just a fraction, if any, of the price. Very sick patients, who spend the most, are the most likely to be largely protected once they hit their out of pocket maximum. Even if they do have to pay, the price will depend on the details of patients' insurance plan and will change over time depending on things like if they have met their deductible. As a result, one cannot quote an accurate out of pocket price without knowing details of a patients plan AND how much they have already spent on care (and often on which types of services). This implies that insurers are best suited to provide

⁵ Desai S, Hatfield LA, Hicks AL, Sinaiko AD, Chernew ME, Cowling D, Gautam S, Wu SJ Mehrotra A. Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees. *Health Aff (Millwood)*. 2017 Aug 1;36(8):1401-1407.

⁶ Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA*. 2016;315(17):1874-1881.
Mehrotra A, Dean KM, Sinaiko AD, Sood N. Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information. *Health Aff (Millwood)*. 2017 Aug 1;36(8):1392-1400

⁷ Gaynor, M., K. Ho, and R. J. Town. 2015. The industrial organization of health-care markets. *Journal of Economic Literature* 53(2):235–284

⁸ Capps, CoryC., David D. Dranove, and Christopher C. Ody. 2017. "Physician practice consolidation driven by small acquisitions, so antitrust agencies have few tools to intervene." *Health Affairs* 36(9):1556—1563.

⁹ Neprash, Hannah H. T., Michael M. E. Chernew, Andrew A. L. Hicks, Teresa T. Gibson, and J. Michael M. McWilliams. 2015. "Association of financial integration between physicians and hospitals with commercial health care prices." *JAMA Internal Medicine* 175(12):1932—1939.

transparency information, and, as noted, many do, though most evidence suggests with little impact even in markets where shopping is possible.

I do not mean to imply that transparency, and more generally price shopping for medical services, cannot work. However, even in areas where we might assume it would work well, such as Lasik surgery, evidence is less promising.¹⁰ Perhaps shopping will work better in areas where there is greater patient responsibility for the price, less reliance on referrals, services that are less complex and, such as in the case of durable medical equipment, involve repeated purchases. Some of the most positive evidence focuses on imaging. Yet, I consider these areas exceptions rather than the rule.

I should also note that transparency may have an impact even if it does not alter consumer behavior. The widespread availability of data may shame high price providers to lower their prices (particularly when journalists have access). There is some evidence that this effect can be salient in healthcare.¹¹

However, one must proceed with caution because it is also possible that widespread availability of information could alter negotiation dynamics in other ways leading to higher prices for some, likely many, patients.¹² This is because payers negotiate discounts with providers. If forced to reveal those discounts health care providers be more reticent to offer them. In fact, there is some evidence, from outside of health care, to support the perverse impact of posting prices.¹³

So where does all of this leave us? Believe it or not, I am generally supportive of transparency initiatives. They are important as we move to newer, innovative benefit designs that attempt to help patients shop. They need not be tremendously detailed and may provide broad categories of price (and/ or quality, which I admitted have not emphasized enough). For example, they can label providers high value or preferred. Simpler information is easier for patients to digest and act upon.

¹⁰ <http://www.hschange.org/CONTENT/862/?topic=topic01#note8>

¹¹ <https://www.chcf.org/wp-content/uploads/2017/12/PDF-MovingMarketsNewHampshire.pdf>

¹² Cutler D, Dafny L. Designing Transparency Systems for Medical Care Prices. *N Engl J Med* 2011; 364:894-895

¹³ Albaek, Svend, Peter Møllgaard, and Per B Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," *Journal of Industrial Economics*, Vol. 45 (1997): 429-43.

As I mentioned at the onset, I believe in markets and the commercial insurance market is responding by providing transparency tools (and redesigning plans and networks) to encourage shopping.

I am more skeptical about public sector initiatives that entail new mandates on providers to provide data because it is particularly hard to provide the right data. I worry that it will not substantially improve the system and may impose administrative costs. I worry that some transparency advocates, in their zeal to help markets work, will override what markets are doing. That said, there is certainly a lot we do not know. While there may be deleterious unintended consequences, there is some positive evidence and I think the shaming effect may be important in the most egregious cases. Moreover, states are experimenting in many ways and there are ways the federal government could support that. For example, requiring ERISA covered health plans to submit data to all payer claims databases (APCDs), which the supreme court, in *Gobeille v. Liberty Mutual Insurance Company*, ruled the states could not do. Providing financial support to APCDs could be a wise investment. Finally, it is clear that healthcare is sufficiently complex that our intuition about how consumers and markets will behave may not be correct. Mine was not. Supporting evidence generation with research funds through AHRQ or other federal mechanisms could help us steer the most productive path forward.

We have a lot of problems in healthcare, I very much applaud your efforts to seek solutions. But please do not let transparency distract you from other strategies, such as supporting alternative payment models, or addressing adverse selection in the individual market for health care, that may be more impactful.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", followed by a horizontal line that extends to the right and then curves upwards.

Michael E. Chernew, Ph.D.

Mr. HARPER. Thank you both for your testimony. It is now the opportunity, the moment that you have waited for, our members get to ask questions of each of you. That will help us very much in that process. And I will now recognize myself for 5 minutes for the purpose of that. And I will start with you, if I may, Dr. King.

Obviously, it is clear that a lot of Americans struggle greatly with how to pay for their healthcare costs. And part of that is they never know how much it is going to cost until they see a bill sometime later. And as you noted in your testimony, a lot of transparency initiatives have focused on changing consumer behavior to encourage them to select lower price providers and services.

But can you elaborate on why these initiatives seem to have limited usage and have mixed results?

Ms. KING. Yes. So, I think there are largely four reasons why consumers don't tend to use these as much as we would like them to. And the first is that insurance often, the structure of insurance often insulates consumers from feeling the price, different prices for different providers.

If you pay a \$20 copay every time you go to the doctor, it doesn't really matter to you what type of doctor you go to; right? So there is some function of that.

The second is that the provider relationship is really important to patients. And it turns out where we have seen price transparency work is exactly on the thing that you noted before, Chairman Harper, is on shoppable goods. We have seen some movement there, where things that people find interchangeable. Right?

So, you might go, you don't care where you go to an MRI, to have your MRI tested or have your CT scan done. Those seem likely to go to this lab or that lab, unless this lab or that lab automatically supplies the results into your electronic medical record and it goes directly to your provider. That might make a difference to you.

But, generally, those are places where people are more willing to shop.

Where they're less willing to shop is on provider, right? They want a recommendation. Let's say that you, your child, or your spouse, or your loved one just got diagnosed with cancer. Are you really going to look at a list of providers and their charges to decide where you're going to go? You're not. You're going to go to a trusted primary care physician, or a family member that's had experience with cancer and ask them who they went to and who they had a good experience for.

So, I think the reality is is that healthcare is so important that patients really want to get advice from someone they trust and not the provider. And that's really why price transparency initiatives that put pricing information that is relevant to the patient in terms of their out-of-pocket costs in the hands of the provider so it's there when they're making that decision, I think have the most, the greatest possibility of a shifting choice on the provider side.

Mr. HARPER. OK.

Ms. KING. And the last thing is that there's very, as Dr. Chernew pointed out, there's very little standardization in healthcare pricing; right? So, if you look at one, if you look at one sheet and it says, well, you can get an MRI for \$300, but then you don't know if the MRI needs specific dyes or other things accompanying it, it's

very hard for a patient to navigate that and to figure out what the overarching price will be for that.

Mr. HARPER. All right. Thank you very much.

Dr. Chernen, in your testimony you noted that there are several institutional features of healthcare that make it difficult for transparency alone to have a significant impact on the market. You do highlight however, that the transparency initiatives are important as we move to a newer innovative benefit designs that attempt to help patients shop.

Can you please elaborate on that point?

Mr. CHERNEW. Of course. So, let me say for those of you that don't know or may not care, I chair the Benefits Committee at Harvard University, which means I advise the provost on what we, as an employer, should do for the benefits for our workers. And we've been very worried about the variation of prices within Massachusetts, which was pointed out. And so that was painful, thank you.

So, when we think about what to do we start with how we might change our benefit designs to incent our workers to make more informed choices about providers. One cannot do that without having the relevant information available. So, if you want to do tiered network, if you want to do reference pricing, if you want to do any type of benefit design that involves incenting patients beyond a flat, say, \$20 copay, it's important that you have the tools to provide information to them. In that way I think transparency is important. And you should know all of our vendors will provide such transparency tools should you decide to do that.

Mr. HARPER. Are the right to shop laws that also provide the financial incentives for consumers to choose the lower cost options perhaps, are they likely to have an impact do you think, a bigger impact on spending?

Mr. CHERNEW. I'm not familiar enough with all of all the laws, so I would defer to Dr. King. But I think that the general sense that allowing patients to shop and supporting their ability to shop when they want to I think is valuable. But because of all of the institutional features I think that alone is not really what's going to be helpful.

What we really care a lot about is even if you're not shopping you just may want to know up front what you're going to have to pay. And just getting that, which seems incredibly reasonable, is hard to do. And we're working through that.

Mr. HARPER. Thank you very much.

The chair will now recognize the ranking member of the subcommittee, Ms. DeGette, for 5 minutes.

Ms. DEGETTE. Thank you. Mr. Chairman, just to show how bipartisan this subcommittee can be, you just asked my question. So I am going to follow up on what you were talking about. And I will start with you, Dr. King.

And what I want to ask you is what percentage of healthcare costs are these things that would be negotiable to most patients, the MRI, the lab tests, issues like that? And what percentage is the things they are less likely to want to negotiate on, like physician services?

Ms. KING. I think it's a great question. And I am not, I am not a health economist. I'm not studying, somebody who studies all of that percentage, so I don't know exactly.

I know that in studies, there was a study done that looked at Anthem, and United, and some other big health insurers, and it suggested that if they used reference pricing for their shoppable items, for their laboratory tests, that they would be able to bring down costs. I think it was on the order of around 10 to 15 percent.

So I don't know the exact number of laboratories. So maybe Dr. Chernew knows that.

Ms. DEGETTE. Well, he is a health economist.

Ms. KING. Yes. He may know.

Ms. DEGETTE. So I think I will ask him that.

Mr. CHERNEW. In great humility, there's a lot of things I don't know.

Ms. DEGETTE. Even though you are at Harvard?

Mr. CHERNEW. Especially because I'm at Harvard.

Ms. DEGETTE. Good answer.

So, so you don't have any idea what the percentage would be reduced?

Mr. CHERNEW. Advocates of shopping will give you a very big number, 60, 70 percent.

Ms. DEGETTE. Yes.

Mr. CHERNEW. In for realistic numbers about what really could be shopped, I think you're probably talking closer to 10 to 15 percent of services.

Ms. DEGETTE. That is the same thing Dr. King just said.

Now, now if you, if you did have increased transparency and if you could encourage patients to actually look at the sources, with physician costs even though, even though people, I mean I am not going to pick the cut-rate physician over the more expensive one that might have gotten a good reference, or whatever. But would there be some incentive for physicians to, on their own, maybe tamp down some of their rates?

Mr. CHERNEW. So, the answer is if the markets were working well there would be an incentive for physicians to change and facilities to change their prices. And you've seen some of that. I really don't associate that with transparency, I associate that with benefit design, things like reference pricing.

I also think there's evidence, we've done a lot of work on alternative payment models, which I know is not the specific subject of this hearing, but when physicians are in payment models that give them an incentive to shop—

Ms. DEGETTE. Right.

Mr. CHERNEW [continuing]. They are much more active in shopping because they will change their referral patterns if they get to keep some of the savings if they're more efficient in their referral patterns.

So, really I think transparency should be thought of as a tool that supports other impactful things as opposed to an end in and of itself.

Ms. DEGETTE. Dr. King, did you want to add to that?

Ms. KING. Yes. So, on the reference pricing point, so the way that reference pricing works is that an insurer will pick a fee that it de-

cides that it's an amount that it's willing to pay for a particular service. And then any provider that charges above that, the patient has to pay that out of pocket.

And what the studies have shown with respect to that is that a number—there's been a decent amount of savings from patients saying they don't actually want to go to a higher-priced provider, but there's been a 30 percent reduction in provider costs overall, that they have dropped their prices to be under the reference price to get a broader volume of patients. And so that might be, that might prove to be helpful.

Ms. DEGETTE. Dr. Chernen, do you want to?

Mr. CHERNEW. I think Dr. King's referring to a study by Jamie Robinson and colleagues about a program that CalPERS did in California Anthem. There's a lot of things they did besides just reference pricing. So it's a very complicated thing. And they were a very big purchaser, which is helpful.

I think we looked at reference pricing for our employees. And one of the problems we had was if you pick a price and then the patient's responsible for the amount above that price, you actually have a lot higher bills that they have to pay.

Ms. DEGETTE. Right.

Mr. CHERNEW. Substantially higher bills. And the whole reason you're here is because you're upset, I'm upset that the patients are facing very substantial bills.

So, we are trying to find ways in our benefit design to support shopping without going through the full risk that reference pricing might impose on patients should they not shop. So, it's a complicated tradeoff.

Ms. DEGETTE. So, what did you do?

Mr. CHERNEW. We decided not to recommend reference pricing.

Ms. DEGETTE. OK.

Mr. CHERNEW. And you should know, going in I really wanted to recommend it because as an economist I thought it would be a victory.

Ms. DEGETTE. Yes. And so what it is sounding like to me is that while we can, we can work on some of these transparency issues—Dr. King, you mentioned your five items and, don't worry, they are in your testimony, too, so even though you were kind of cut short—but, but we should also look at other ways of structuring these insurance plans which may make incentives for providers versus just the patients.

Thank you. Thank you, I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the vice chairman of this subcommittee, the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you very much. Appreciate you all being here today. And obviously this is a very complicated subject, and I do appreciate it.

I wish there was some way people could go in and say I have got to have this procedure and, like a car, you could say if you are getting this, the fancy wheels, then you pay more, et cetera. But it seems that that is outside of our realm right now. Although one

would hope that with all these young computer whizzes coming on that somebody might be able to figure out how to plug all that in.

And I do agree that there are some things, I am going to pay more for the doctor that I know. Happy to do that, and able to do that, fortunately. Some people aren't. And so we have to try to look at some of the things that you all already talked about in relationship to insurance and getting the ability to say how much is this going to cost me out of pocket before you go forward I think is important. And you all touched on that as well.

So, you all are dealing with this huge, complicated matter. And my questions are much simpler. I have just been really concerned. We had a hearing in the Health Subcommittee where we had all the providers lined up. And it was shocking, I had heard rumors but they actually confirmed that because of the way the system currently works there are cases where you could go to your pharmacist with your insurance company and your PBM and say, I want to get this drug, how much will it cost me if I don't use my insurance? And sometimes it is less if you don't use your insurance than it is if you do use your insurance because of the complicated formulas, and so forth.

And Delegate Todd Pillion in my district out of Abingdon, Virginia, got a bill through the Virginia legislation—I heard there were 22 others this morning—that said you can't have those gag orders anymore.

Dr. King, do the states eliminating those gag orders, do we find that that make a whole lot of difference when they go to the pharmacy? Do they sometimes figure out that they are better off nothing using their insurance because of the PBMs, et cetera?

Ms. KING. Thank you. It's a great question.

So, I think a lot of these laws are new and so we haven't been able to really do the studies on them. But I think in terms of allowing pharmacists to actually say to the client at the desk, by the way, if you go outside your insurance or you get this generic you can save a lot of money, I can't, because pharmaceutical drugs in a large respect are those kinds of interchangeable drugs, interchangeable products, and so I think that that should have some substantial effect. And the idea that they were prevented from doing so by contract before is unconscionable to me. So, I think it's great.

Mr. GRIFFITH. Mr. Carter has a bill I am glad to be a cosponsor of to make that a Federal policy. And it is really interesting. I was discussing it back home and lady said, yes, that happened to my sister by accident. Her insurance company initially stated that they wouldn't pay. And so she paid for the prescription herself. Then when it came time to renew they said, oh, we changed our minds, we will pay for that particular prescription, and she found out it was more.

She called her pharmacy and said, what is this, it cost me more when I am using my insurance?

Ms. KING. Yes.

Mr. GRIFFITH. He says, yes, I can't tell you about that but if you will ask me to do it outside of your insurance you will only have to 17 instead of paying 50.

Ms. KING. Right.

Mr. GRIFFITH. And so, I think it is something we need to pass. And there are a fair number of patrons on that.

But it was clear to me that we need to look at the PBMs along with all the other things that you all are mentioning as part of the transparency. I know they serve good purpose.

But, again, Virginia on this, and it is my home State, that is why I keep referencing, but we had Delegate Keith Hodges out of Gloucester directed the State Bureau of Insurance to report to the General Assembly about how PBMs charge for their services and whether they save money or make healthcare costlier. Among the findings of the first PBM transparency report as a result of his work, mandated by that language, last year there were 152,250 payments, with total PBM markups of 3.5 million between July 1 and September 21.

The differential or spread on each claim ranged from 1 penny to \$4,932.

Do you think that having more transparency and more oversight over PBMs and what they are doing—I know they work hard in some cases and save money, but in other cases they are actually costing the consumer—do you think that would help?

Ms. KING. Yes, I do.

Mr. GRIFFITH. Dr. King, you do.

Dr. Chernenew, do you have an opinion?

Mr. CHERNEW. You can call me Michael, please.

Mr. GRIFFITH. Michael.

Mr. CHERNEW. I think as a matter of principle people should be able to get the information that they need. So, just on the pure principle of it.

In terms of the market demand, that gets much more complicated. I, I didn't talk about prescription drugs because a lot of the situation that you're discussing arises because of the complicated rebate rules that are going on in the prescription drug market. And those rebates both in some ways they help markets work, but in other ways, and I think more dominantly, they make it much more complicated and much more difficult to have markets work well in healthcare.

And so, I think that while we could debate conceptually what the ability, you should have the ability to negotiate, I think the fact though we live in an environment where it's just so complex for people to get the price and get simple information, they're told that by contract they're not allowed to tell them, I think it's just a matter of principle that the situation shouldn't arise, even though it may well result in some people paying more because the discount that currently the PBMs can get might be less because they don't want everybody to know when they're getting the discount. That's basically what the problem is.

Mr. GRIFFITH. All right, I appreciate it. And I think that for a lot of our folks back home, they don't understand all the big stuff. But they understand when they go to their pharmacist and they feel like they are being overcharged.

I appreciate it, and yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlewoman from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman.

I want to return to what providers and insurers can do to help lower the costs through their transparency efforts. Because I think you correctly stated how folks feel, that if their doctor recommends something, I mean, it is pretty rare that a patient, a neighbor is going to go shop and do something else.

So, Dr. Chernew, you, you said, OK, alternative payment models can be one way. What else on physicians, because they play such a central role on consumer behavior?

Mr. CHERNEW. So, first let me say I really wish I could come here with some silver bullet and solve the problem. And I can't. Because anything I'm about to say is going to have potential deleterious consequences.

Most of the insurers I know, all of the insurers I actually know, are struggling to find ways to address the healthcare cost problem. It is not that insurers want healthcare spending to be high or they're not working on it.

Essentially what matters is the interaction between the patient and the physician, the treatment that's given, and the price that we pay for that. The way to address that is some combination of payment reform and benefit design. And you're seeing a ton of private sector initiatives to do that. And where we are right now is employers in the market sorting through which ones work for them in which particular ways, and we're trying to learn what works better than not.

So, alternative payment models honestly is my favorite. I'm a big believer in benefit design changes. So the evidence on high deductible health plans that are HSA coupled isn't as strong as I would like as an economist in general. There are some things that I would recommend, like the way chronic care medications are treated in the HSAs is something I think are probably a good thing to help people being able to shop. Things like that.

But there is not a specific Federal thing that one can do. And the challenge that you will face—and again I say this in a totally non-partisan way—is where the regulations should step in and stop at least the most egregious cases. Because there are some really out-of-network billing things, there are some really egregious cases that are just unconscionable that should probably be stopped by regulation. And I honestly think that transparency is not the mechanism to get at those types of things.

To the extent that the private sector can build transparency tools, which I am supportive of, and the States can try different ways through their All Payer Claims Databases, I think that is wonderful. But I think fundamentally my advice would be focus on rules to prevent the most egregious situations where people in an emergency room are paying some huge out-of-pocket thing.

Ms. CASTOR. Right.

Mr. CHERNEW. And telling them that matters. But, honestly, I would say just prevent that.

Ms. CASTOR. So and, Dr. King, your number one recommendation was on ERISA. And ERISA was a law passed in the 1970s that said, across the country you have to have certain standards.

Ms. KING. Yes.

Ms. CASTOR. So, why would that be so important for us to get into to help lower healthcare costs? You want to empower the states to do additional things I guess?

Ms. KING. So, basically ERISA, the way that it is written because it's trying to promote uniformity and place benefit plan regulation across all 50 states has a very broad preemption scheme. Which means that it will come in and negate any state law that relates to an employee benefit plan, including all the employer health plans.

Now, there is a savings clause as a part of ERISA which says that any state insurance law that directly regulates insurance will be saved from ERISA preemption. But there's the next part of ERISA says that it doesn't deem self-insured employer plans to be insurance, even though that's the way that the vast majority, or at least half of our employees get their insurance is through self-insured employer plans. Right?

So, any law that's passed by a state to regulate health insurance or employer-based insurance is going to be preempted by ERISA as it applies to about half of our employees. And —

Ms. CASTOR. Who would oppose it?

Ms. KING. I think industry would oppose it. Right? They, they like not having regulations apply to them in that way. But it is crippling state All Payer Claims Databases, which have demonstrated that they can do a lot.

They're doing a lot with the information they have. But if they had all the claims, healthcare claims in a particular state, they could really get a handle on what's driving cost, where is competition not working, what thing, what mergers and acquisitions should or shouldn't go through.

And it also provides the foundation for every, like, for the majority of other, the other solutions we're talking about, so, allowing individuals to have better price information for what it would cost them, for putting that information into the hands of providers, I mean providers and insurers. Like, it would just sort of seed a lot of other efforts. Reference pricing would be based on that, and other things.

So, I think addressing the ERISA problem—and I have a number of ways, a number of ideas of how you could do that—I think is foundational to any sort of transparency initiative that you would propose.

Ms. CASTOR. Thank you very much. I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from Texas, Mr. Barton, for 5 minutes.

Mr. BARTON. Thank you, Mr. Chairman. And it is always good to have hearings like this to try to, through bipartisan basis, get facts on the table.

My first question is just kind of a general question. I have been on this committee 32 years. I have been involved with some of the major healthcare issues over a number of times. One of the most vexing issues we face is pricing drugs. And to my mind, except for the long-time over-the-counter drugs like aspirin and things of this sort, there is no rational explanation for how we price drugs.

I think the over-the-counter drugs that have been on the market for decades, in some cases hundreds of years, they are pretty much priced like any other commodity and it is cost-based, distribution-based, advertising. You pay more for Bayer aspirin than you do for the Walmart generic brand, but they are basically aspirin.

But I would like you, Dr. Chernew, to go back to the Harvard Business School and have them come up with a flow chart and explanation of how we price Lipitor, or how we price Plavix, or how we price the new stem cell-based drugs. Do either one of you want to defend the current pricing system for these, these new drugs that are coming on the market, or even try to explain it?

Mr. CHERNEW. When you said comment, I thought you were going to say comment, I was going to jump in. When you said defend I had to back off.

But I will do my best. The——

Mr. BARTON. Do it in about 30 seconds because I have got two or three questions. Give me the executive summary.

Mr. CHERNEW. New drugs provide great value. I think that is indisputable.

Mr. BARTON. I agree with that.

Mr. CHERNEW. We have a patent system that supports them. And the drug companies charge what the market will bear. And that, fundamentally, both gets us really good drugs and creates huge amounts of problems.

And that was my 30 seconds. I'm happy to talk more.

Mr. BARTON. Well, that is pretty rational. The drug manufacturers charge what they think the market will bear. But you go through these convoluted, average wholesale pricing and 340B discount drug program.

Mr. CHERNEW. That's all just a distraction. They're basically charging what the market would bear. And because of a bunch of rules, it's much more complicated than that. And the question is how we want to support innovation and pharmaceuticals, which we want to support because it——

Mr. BARTON. We do.

Mr. CHERNEW. And that's where the problem comes in.

Mr. BARTON. Dr. King. Then I have got two more questions.

Ms. KING. I just want to interject that I think Dr. Chernew is totally right that we get, we tend to get good value for new drugs, for most of them. Where we're really not getting good value is where we've already had a drug that has been on patent, expired its patent life, and then they change a tiny little bit of this drug, get an entirely new patent, run prices up for 20 more years. There's a lot of things that we are not getting good value for that remain in patent.

And if you want to look strongly at how to fix drug pricing, I would look at how drugs are patented and what we allow a whole re-upping on the patent.

Mr. BARTON. I think that is valid.

All right, I want to go to the very bottom line here. I have a constituent in Texas, a real estate agent who is on Medicare. And her doctor gave her a coupon for a prescription drug covered by Medicare. She took it to her pharmacist and the pharmacist said,

“Great, but I can’t, I can’t take this coupon because you are on Medicare.” Medicare doesn’t take coupons.

So I got with the Congressional Research Service and some other groups and found out that for some reason when we established Medicare we don’t allow senior citizens—and we started covering prescription drugs—we don’t allow senior citizens to use coupons if they are under Medicare.

So, Congressman Doyle and I have got a bill, we are going to introduce it either this week or next week, that says if you are on Medicare and you have got a coupon from your doctor, you can’t use them for generic drugs, but for any other drug you can. Good idea, bad idea?

Mr. CHERNEW. So, I appreciate your constituent’s problems. I think the challenge is most of the time in the patent system what the market will bear is not distorted by insurance. In healthcare it’s distorted by insurance. So the problem is if you take any consumer incentive away by the coupon, the actual price for the drug the market will bear goes up. And that’s what the tension is, is that if you want the consumers to——

Mr. BARTON. Well, then the manufacturer doesn’t have to give the coupon. If they don’t give the coupon to the doctor, the doctor doesn’t give it to the patient.

Mr. CHERNEW. No, the manufacturer likes giving coupons because then they charge a higher price and the insurer can’t use the cost function.

Mr. BARTON. Then we should just stiff the Medicare recipients?

Mr. CHERNEW. Is my time up? I hope so.

[Laughter.]

Mr. BARTON. It is not complicated if you are an elected member of Congress and all of a sudden Medicare recipients start showing up at their town, town hall.

Mr. CHERNEW. Yes, I, I totally agree. The challenge at the core is you want the market to discipline the providers, which requires people having to pay. And when people have to pay, it turns out they don’t like having to pay. And therein lies the problem with coupons and a bunch of other distortionary things.

So, I agree with you. And we’ll have to have a longer conversation on how to deal with it.

Mr. BARTON. I think that is yes, he agrees with me.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlewoman from New York, Ms. Clarke, for 5 minutes.

Ms. CLARKE. I thank you, Chairman Harper, Ranking Member DeGette, for convening this important hearing examining state efforts to improve transparency of healthcare costs for consumers. Additionally, I want to thank our witnesses for providing your expert testimony here this morning.

This is a critical issue that is most deserving of Congress’ attention as we work with industry to ensure consumers have a positive experience on their healthcare journey. In my home State of New York, since 2015 we have an out-of-network law that protects patients from surprise billing when services are performed by non-participating providers. This same law also protects New Yorkers from bills for emergency services.

The focus on transparency and consumer protection are needed so that consumers will not have to continue paying more than their usual in-network cost sharing and/or copayment amounts.

So, I have a couple of questions. Dr. King, how effective have state efforts been to ban surprise out-of-network hospital bills? And what more should we be doing to prevent this?

Ms. KING. Thank you. It's a great question.

I think surprise billing is a really important issue for just consumer protection in general. So I think that we have seen a number of different types of laws to protect consumers from surprise billing. So there are those that, as Dr. Chernew said, ban the practice outright, just say you will not be exposed, especially in emergency services, you will not be exposed to prices that are higher than your in-network copay for emergency services and other things.

And I think those are very effective. At least they're protecting the consumer. And then we allow the bigger fish in the game, the insurance companies and the providers, to hash it out over what are reasonable reimbursement rates. And that's what we have in California.

But there are others, there are lots of states that are passing laws right now that just say that a person should be informed that they may be being seen by an out-of-network provider, or that they, when they arrive at the emergency room, someone who takes care of them might be an out-of-network provider and they might experience other charges.

And I think that these laws, while well-intentioned, don't reflect accurately the reality of the patient experience. If you show up at the emergency room, you are in an emergency situation. You are signing whatever it is that you're signing and then you're going to get help. And I think that someone telling you that you may be subject to out-of-network law, out-of-network bills at that point is not that helpful for you.

So, I think we need to focus on the laws that seven states have passed that really just make it very clear that patients in these specific situations will not be subject to copays that are higher than what their in-network charges would be, and then let everybody else hash it out.

Ms. CLARKE. OK. And, Dr. Chernew, in your written testimony you note that efforts in New Hampshire have had a modest impact on healthcare spending. What was it about the reforms in New Hampshire that have enabled costs to go down, albeit slightly?

Mr. CHERNEW. So, the study by Zach Brown in Columbia is what I, who is at Columbia is what I was referring to. And they found by looking at MRIs what I consider to be a modest impact on a service where you often see impacts, like MRIs.

So I think there were some things about that. They had insurer-specific prices. They knew whether you were in your deductible or were not in your deductible, things like that.

So, I think as those laws go that's a reasonable law. I think it's a mistake to believe that doing things like that are going to solve the basic problems. And as far as I know, New Hampshire has not really solved all of the problems. Maybe there's someone here from New Hampshire.

But I think in the end of the day through their All Payer Claims Database they were able to do some things that were valuable. And to the extent that you can support the All Payer Claims Databases, I think you might be able to help on the margins the system get a bit better.

I still think private sector initiatives could have the potential to be more impactful.

Ms. CLARKE. So, Dr. King, could you describe any other promising state efforts to improve transparency of healthcare costs for their citizens?

Ms. KING. Yes. I'll comment just really briefly on New Hampshire and then I'll talk a little bit about Massachusetts as well.

So, one of the things that New Hampshire did through their All Payer Claims Database is they have a website called New Hampshire Health Costs which you can go into. And I checked it out this morning because I had heard good things about it. And basically as a, as a patient you can go there and check off this is the health insurance plan that I am in, I am in Anthem and I want to get this kind of procedure, and I want to do it with this particular provider. And they'll tell you, they'll run down the cost. And they'll run down the cost for that provider and they'll show you how it, how it compares to other providers.

Now, that doesn't tell you your specific out-of-pocket costs and it doesn't tell you where you are in your personal deductible, but I think that is more helpful than what we've seen in a lot of other states' price transparency initiatives.

Now the other state that I want to highlight here is Massachusetts. And Massachusetts has gone a long way with their All Payer Claims Databases. But they also have their Health Policy Commission, which is an arm that is designed to analyze that information and really mine the All Payer Claims Database for a whole host of policy reasons. And they've been able to interject and produce reports, annual reports on spending, annual reports on the drivers of costs, but also interject in a number of different places where, where that information would not have otherwise been available to inform policy decisions, but also to inform patients in that case.

So I think there are consumer-facing things that are very useful, although I do agree that some of the private initiatives from insurers are better. But I do think that having the Health Policy Commission there to really analyze that data has been a very useful step as well.

Ms. CLARKE. Thank you. I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. And I have got way more questions than I can package into 5 minutes, but we will do our best. And I may submit some for the record.

I do appreciate both of you being here today. Let me just ask you a question, Dr. Chernew, since you brought up about the private sector initiatives versus the All Payer Claims Databases.

I pointed out in my opening statement, Texas has Texas PricePoint. I believe it is Texas Hospital Association that has done that. So, good on them for having done that. But is that not helpful

for them to have done it? Does that delay getting an All Payer Claims Database set up in the state? What are some of the tensions there?

Mr. CHERNEW. I think it is at the end of the day probably marginally helpful as opposed to not. I don't think it delays All Payer Claims Databases.

I think because all healthcare is local and the states are going to do different things, I'm sort of a state experimentation kind of person in this space. I wish I could tell you I knew what would work. I don't like sounding as skeptical as I am. So I think the more we can allow states to do different things and then study what they're doing, I think the better.

Mr. BURGESS. And, Dr. King, do you have any thoughts on that?

Ms. KING. I tend to agree. I think that on balance it's probably helpful. I think any attempts to provide transparency are generally useful. I don't think it probably delayed an All Payer Claims Database unless you were considering that as the alternative option and went with this one.

I think that an All Payer Claims—so, in terms of the private entity tools, I think those tend to be much more useful for consumers. Right? And so, United Healthcare they go in, you type in your name, you get into the system, and it tells you what your actual, where you are in your deductible, what your copay would be for different people.

And I think All Payer Claims Databases allow you to use the information for a lot of different purposes; right? So that's sort of the difference. One is very targeted at individuals, but you also have to be in the plan in order to see that information.

Mr. BURGESS. Sure.

Ms. KING. Right? You can't get that information when you're choosing your plan. Although Massachusetts I think just has a law coming down that would enable that, for you to see different prices as though you were in different plans.

Mr. BURGESS. Txpricepoint.org you would not have to be in a plan. That is a —

Ms. KING. No. But it tells you—

Mr. BURGESS [continuing]. Public hospital provides database.

Ms. KING. But it doesn't tell you the price that you would pay for your insurer.

Mr. BURGESS. No, it does not.

Ms. KING. Right. So that is very hard to know what to do with those prices.

Mr. BURGESS. So, every time I see that TrueCar ad on T.V. I wonder why we don't have TrueCar for healthcare. But then as someone who had a health savings and account for years and year and always has paid the highest out-of-pocket costs for everything, hospital labs included, I was a big believer when I first heard about Theranos. And I thought, oh man, a cheap way to get a bunch of blood tests done. I'm all in. Except the reliability suffers.

Ms. KING. Yes.

Mr. BURGESS. So there is a caveat there, I guess. Is that the correct observation?

Mr. CHERNEW. Yes. And remember, it's TrueCar, it's not TrueCarborator; right? And it's TrueCar.

Mr. BURGESS. So, I think, Dr. Chernew, I think you mentioned the alternative payment methods. And going back to when the Secretary of Labor was Secretary of Health and Human Services he did a demonstration project, a physician group practice demonstration project where they dealt with some alternative payment mechanisms. I think, if I understand the history correctly, ACOs kind of grew out from there.

But can you speak to that? Is there a way to foster the development of what perhaps Secretary Leavitt's original idea was there?

Mr. CHERNEW. Yes. And I think, again maybe a little far afield, Medicare has been very innovative in the whole range of payment models. But I also can't tell you what the right type of payment models are. But I think—

Mr. BURGESS. Neither can we. But we are learning, I hope.

Mr. CHERNEW. There you go. But the more we support alternative payment models, in many ways the better.

One thing that I think does matter is to understand that the price from the point of view from the physician is different than the price from the point of view of the patient because the patient is buying some episode of care. The physician is delivering a small part of that, the same with the facilities.

So, the more for example supporting bundled payments, which Medicare is doing, the more you can support that type of thing, and the more payment moves towards more consumer-oriented sets of things that are being purchased, the closer you get to transparency because then someone will know what does it cost for a colonoscopy, not what does it cost for the technical component, the professional component, the anesthesia component, et cetera, et cetera.

Mr. BURGESS. But people still buy on provider as well as on price. Which just brings me to the final thought, and I will close my section out.

In the lead-up to the Affordable Care Act there was a lot of concern about physician-owned hospitals. And in fact, remember, physician-owned hospitals got whacked in the Affordable Care Act. Mr. Chairman, I am going to ask unanimous consent to insert a letter or a article into the record about physician behavior with physician-owned facilities.

Back in my world it was all about time. I got paid the same amount, regardless whether the patient went to an ambulatory surgery center or to a community hospital. The lab processing from my reimbursement's perspective was identical. But the cost to the patients was a fixed rate in an ambulatory surgery center, and the sky's the limit in the community hospital. I am oversimplifying. But nevertheless, that is I think one of the pressures that we are going to have to consider as we work through these.

But, again, I ask unanimous consent to put this article into the record.

Mr. HARPER. Without objection.

[The information appears at the conclusion of the hearing.]

Mr. HARPER. The gentleman yields back.

The chair now recognize—

Mr. BURGESS. I want the gentlelady from Colorado to read it before she accepts. I thought I had found a way to get you to read my articles.

Ms. DEGETTE. I will take your word.

Mr. BURGESS. All right. Thank you, Mr. Chairman, I yield back.

Mr. HARPER. And that was on the record by the way.

And the chair will now recognize——

Ms. DEGETTE. But not under oath.

Mr. HARPER. Not under oath.

But the chair will now recognize the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you, Mr. Chairman.

Overall we know transparency is a good thing and leads to better understandings of market dynamics and better ways to help everybody come up with good policy that is going to really lead to a more cost-efficient way of providing better healthcare for the American people. However, there are certain things that transparency is good for and the market really focuses on.

Like, for example, if you had the ability to make the choice, and knowledge to know the difference between the products in a situation where you can actually make a decision, and not under duress, or when you are in a coma, or when you are in cardiac arrest or something going into the emergency department, and there are some things that transparency obviously can work.

So, in your statement, however, Dr. Chernew, you note in your testimony that “many studies, including several of my own and those of my colleagues, find that transparency has minimal, if any, impact on the market.” You go on to explain why transparency results in only minimal impact on price.

Dr. Chernew, it sounds like the bottom line is that it is somewhat folly to rely upon transparency as the magic bullet to bring down healthcare costs. Is that correct?

Mr. CHERNEW. Yes.

Mr. RUIZ. OK. In what situation does transparency work?

Mr. CHERNEW. When there’s more commodity type services, when they’re not as connected to things and you have time to shop I think transparency works.

I think independent of shopping, transparency works just to tell people what they would have to pay out of pocket. Just knowing. So, you’re not going to shop, it’s just you don’t want to get a bill after the fact that’s way higher than you thought.

So, I think transparency is useful. I think it needs to be coupled with other things.

Mr. RUIZ. But you are saying it is not what we should be focusing on?

Mr. CHERNEW. I think there’s a lot of reasons why healthcare markets don’t function well. Transparency I would put down on my list for what that’s true.

I think it’s important, let me say, what I worry about, for example, is insurance inherently, unlike most products is a pooled product. I’m in with a lot of other people on the same plan. I worry that if we allow the benefit packages to deteriorate to the point where people are paying a lot out of pocket and we separate that market through a range of things that are going on that I won’t mention—

it might be too partisan, I don't mean it to be—that people have higher out-of-pocket bills because they won't understand when they bought the insurance plan what was covered. They'll go to the doctor and they'll realize that what they thought was insurance wasn't that good. And it's very hard to make that work well.

Mr. RUIZ. So, do you think that putting too much weight on transparency to reduce healthcare costs is a distraction?

Mr. CHERNEW. I worry that that's the case.

Mr. RUIZ. OK. I am a doctor. And I know that patients rely on doctors' knowledge, and training, and years of experience to make decisions that will be to the best benefit for the patients. And I know that it is difficult for patients to then, if an orthopedic surgeon says I recommend a titanium type of metal for your knee replacement, that a patient in general is not going to do the research or have the know-how in order to determine what kind of equipment they want for their knee to make that best judgment.

But I do think that there is some value in transparency. I think it is just what Dr. Burgess said earlier, it is insane that one hospital will charge, I don't know, I'm just making these numbers up, but \$2,000 for a colonoscopy. And then, like, across the city in the same, same region another hospital charges \$10,000. So why is that?

And we should understand where are the mechanics that go into that so that we can identify, in those cases when you do have the time to choose which studies or which equipment you want where you can have the knowledge and have the time, and under the situation, to make that possible, I think we should focus on that.

But, Dr. Chernew, you also mentioned that if the objective is to meaningfully reduce healthcare costs, other strategies such as addressing adverse selection in the individual market for healthcare may be more fruitful. Can you expand on that?

So, if the objective is to lower costs are there ways to combine transparency initiative with some of these other efforts to lower costs? Can you go into that?

Mr. CHERNEW. Well, let me talk about two separate things very quickly. The first one is transparency is important to support almost all of the various new benefit design things we do. It's important for a range of public regulation things. I think there's a bunch of reasons why transparency matters. And I think it's unconscionable, some of the stories that I'm sure your constituents have told you. I think that's a really big deal.

That said, the biggest problems we have in a lot of healthcare markets aren't related to transparency, they're related to how we hold the market together and how the benefit design packages play out. So, at Harvard we control exactly the benefit package. We push everybody into it. It's pooled, it works.

If you allow markets to spin out of control and let people do various things there's implications of that that differ from markets for cars, or markets for asparagus, or things like that. So, figuring out how to address those types of problems so you don't have individuals that end up in insurance plans where they're going to be charged a lot out of pocket I think are important.

Mr. RUIZ. Harvard. Harvard Business School?

Mr. CHERNEW. Harvard University. Harvard University has a Benefits Committee that offers benefits for all of the schools.

Mr. RUIZ. OK.

Mr. CHERNEW. So, Business, the Medical School, the main part. And we advise the Provost, for the non-union workers, about how to deal with our challenges. And we have a lot of challenges.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlewoman from Indiana, the chair of our Ethics Committee, Ms. Brooks, for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

And I want to stay on that line of questioning, Dr. Chernenew. Speaking of employers, and you mentioned Harvard specifically, and even some insurers provide transparency tools to their members or their employees, and have redesigned plans and networks to encourage price shopping, can you describe some of the features of the price transparency tools that are adopted by employers and insurers, whether it is Harvard or others, and how they differ from the state transparency initiatives?

Mr. CHERNEW. Yes. So, and again Dr. King mentioned, if you are in a plan that offers one of these types of transparency tools and you know you need a service, you can go in and type the service. Now, that actually sounds easy. But remember, if you're shopping for a CT scan, there's 50 types of CT scans, and it depends on what the dyes are, so it's not as easy as you think.

It will aggregate out and try and come up with a number. It will combine the physician and the hospital. Because you don't care how much is going to the hospital and how much is going to the physician, you care totally what are you going to pay—

Mrs. BROOKS. Right.

Mr. CHERNEW [continuing]. For the whole thing. It will know, and again it won't know perfectly because there's time lags, it will know within reason where you are in your deductible. So, if you are over the top of your deductible it will give you a different price quote than if you haven't yet spent your deductible.

Most of the public non-insurer-based tools don't have all that information, so they cannot tell you very accurately what you would pay. They don't. We know what prices our carriers have negotiated with all the different providers. But most public tools don't know—New Hampshire being an exception—the prices that different providers have negotiated with different insurers. And they certainly don't know where you are in terms of your deductible.

Mrs. BROOKS. And do you, are you familiar with a lot of private tools like what you have just described, and are these types of tools, whether they are insurers or employers, are they proving to be effective in changing consumer behavior—

Mr. CHERNEW. So, the tools—

Mrs. BROOKS [continuing]. And reducing steps?

Mr. CHERNEW [continuing]. Are almost always tools that employers offer but the insurers make. The employers don't do much. They buy things. So, the insurers are the ones that offer the tools. Or other, there's a firm Castlight, for example, that's well known for having these types of tools and selling to employers who can buy access to them. And they have been, unfortunately, disappointingly ineffective.

Mrs. BROOKS. Why, do you believe?

Mr. CHERNEW. Well, for one, even the best of them are very complicated. The people care more about their physician than the tool, so they're hesitant to shop. And in many cases the employers have provided the transparency tools but haven't designed their benefit packages in ways that make them really salient. So you get back the same result.

Even if there—you've mentioned, several people have mentioned that there's wide variation in prices across markets, \$2,000 and \$500. But most patients don't pay \$2,000 and \$500 to their employers, most of them only pay—if you were at Harvard you'd pay \$30 flat fee no matter where you went to. So the tool doesn't help you that much.

Mrs. BROOKS. Dr. King, would you like to comment on the private initiatives, private, the private tools?

Ms. KING. Yes. So I would just basically reiterate what Dr. Chernew said, that they haven't seen the kinds of results that they would be looking for. And I know that Castlight has been, is employers basically buy Castlight Health and offer it to their employees. And they found very low engagement from employees.

I think a lot of employees don't want to shop for providers. They don't necessarily want to shop. They will shop a little bit for the shoppable services. But they haven't seen the overall level of engagement has been about 3 to 6 percent on a lot of those tools.

Mrs. BROOKS. Well, and I would like to ask both of you why do you believe that is the case? Why is it that we have these tools, whether it is a private sector, an employer, or at the state base that states have invested in these, why do we have such low engagement on this issue?

Ms. KING. I think that we largely have low engagement, partly because people aren't incentivized to use them. If you pay the same price you're not that much incentivized to use them. But I also think it goes back to this idea that when you go to your provider and they make a recommendation for you of which provider to go to for your hip surgery, or which lab to go to. Oh, go to the lab down the street. It's unlikely to then, to whip out your laptop and figure out if there's a cheaper provider elsewhere.

Also, a lot of times individual providers prefer that their patients use a particular lab—

Mrs. BROOKS. Right.

Ms. KING [continuing]. Because they know that they get the results quickly, or it goes right into their EMR, or there are some synergies within the system.

And so I think that patients are reluctant to go against their provider's advice or recommendation, which is why you should try to get this information into the hands of the providers so that if they think I would recommend five doctors to do your hip surgery. Oh, two of them are in your network. Let's talk about you'd pay \$500 for this doctor, and you'd pay \$200 for this doctor, let's talk about the benefits and detriments of that. That's what we need.

Mrs. BROOKS. And, Dr. Chernew, anything different on that as to why we have such low rate of use?

Mr. CHERNEW. Yes. I think that it is a mistake to believe that consumers fundamentally want to shop. They actually fundamen-

tally want to pay less out of pocket, and they want things to be simpler. That's what they really want because of all these sort of interactions with their physicians.

And so they tend not to want to go find these things out. You can push at the margins, but as a main view that we're going to use market forces to fundamentally control our problems I think is a little optimistic, as much as that pains me to say as an economist.

Mrs. BROOKS. Thank you both. I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair. And welcome to our guests.

Many states and healthcare systems have implemented a variety of programs that are intended to give consumers additional information about the price of healthcare services on the theory that this will allow consumers to make more informed decisions and perhaps lower their costs. They are listening to your concerns there.

But maybe you can develop for us a little better some of the tools and some of the concerns that we should have.

Academics, including both of you today, have studied these reforms to see what works, what doesn't work, and where we might go from here. I would like to spend a few minutes discussing with our panelists what the academic literature has to say about these efforts.

Dr. Chernen, in your written testimony you use the example of shopping for a car to describe why transparency doesn't always work to bring down the cost of shopping for healthcare and the like. Could you briefly describe what makes shopping for healthcare different and more complicated than that which we would utilize for products or services?

Mr. CHERNEW. Most products or services are bundled in a way that you care about. So you're not buying the ingredients. When you go buy a meal you don't price out all the individual ingredients, it all comes together.

Healthcare, because of the history of the way in which it developed, and because the reimbursement system was really provider focused so you, remember, physicians and hospitals, they're inputs to providing care. Right? But you really care about the joint product. And so that has made it difficult to simply give prices that have been developed from sort of a payer perspective to consumers who are purchasing from a different perspective. And it, broadly speaking, has been hard for people to shop in that way. Combine that with insurance distorting prices, the reliance on physicians, the complexity of the problem, the salience of the problem altogether has made it very hard for people to shop.

Mr. TONKO. And, also, you wrote in an August 2017 "Health Affairs" article that "simply offering a transparency tool is not sufficient to meaningfully decrease healthcare prices or spending."

So, what did you find regarding these transparency tools? And why were they unable to bring down the prices on their own?

Mr. CHERNEW. They're often offered with the narrative of they're going to help make markets work. And because most people don't

use them, because they're complicated, they don't make markets work that well on their own, and as a result you don't see prices respond.

Mr. TONKO. So, could you describe what conditions would be sufficient to meaningfully bring these costs down?

Mr. CHERNEW. Well, there's bringing costs overall down is challenging. What's sufficient to how transparency tools work, which I believe are true in a limited number of cases, is you need to have services bundled in a way that people can understand. You need to have benefit designs done in a way that make people actually feel the cost at the margin. And you need to avoid a situation in which the physicians that are making the recommendations are, for example, owned by a system, so the physician's going to refer within a system. And once you choose your primary care doctor you're actually choosing a whole referral network they use, and it's very hard to get them to work.

So, I think Dr. King and I agree that the margins is all valuable. There are specific cases. It's really valuable to let people know what they might have to pay out of pocket. But as a fundamental question about what could you all do to all of a sudden use transparency to revolutionize the way that consumers shop, and therefore to control healthcare spending, that's a really tall order.

Mr. TONKO. Thank you.

And, Dr. King, your written testimony discusses the usefulness of state efforts such as All Payer Claims Databases to bring down prices for consumers. These databases are intended to house a comprehensive collection of medical claims data from both public and private payers on how much they pay for different kinds of procedures.

How can consumers use that information in these databases to inform their healthcare decisions? And what are the limitations on this kind of data?

Ms. KING. Thank you. So, basically the consumers wouldn't use the database themselves. The information that's housed in the database would then have to get put into a consumer-facing website like what New Hampshire has on Health Costs. And that has been demonstrated to bring down costs a little bit and allow patients to use it.

So if you have the negotiated rate between a provider and an insurance company in all of these All Payer Claims Databases, and all of the utility, how we utilize healthcare, who patients go to, what they charge, what the negotiated rates are across the State, you could then generate really meaningful information for patients because you would know which insurance company they were in and what that insurance company had negotiated its prices with providers for. And you could use that to populate consumer-facing websites and consumer-facing tools that would provide patients with information on their out-of-pocket costs.

I just want to say that one of the other things that we haven't really discussed today as a driver of costs that affects transparency is the fact that a huge majority of our markets for healthcare are highly concentrated. And one of the reasons why we have such a problem with transparency is that you have provider organizations and provider systems with a large amount of market power and

they can demand to keep their prices secret. They can negotiate things in ways that drive up costs and then, and then hinder transparency to find that out.

And so, if you were really looking, I think transparency is important at the margins. I think it's useful. I think it's generally a good thing in a capitalist society for people to know what they're going to pay. But I also think if we want to talk about competition and why the markets don't work you need to look at the markets themselves and figure out that competition is dwindling and dying because these markets are so consolidated.

Mr. TONKO. Thank you very much. And, Mr. Chair, I yield back my time.

Mr. HARPER. The gentleman yields back.

And the chair will now recognize the gentleman from Georgia, Mr. Carter, for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman. And thank both of you for being here.

Dr. King, I am going to let you continue on because you have hit on the right point, the vertical integration that we are experiencing right now. What you have is you have a PBM who owns a pharmacy. Now the PBM and the pharmacy are talking about buying an insurance company. Now you have got an insurance company, Cigna, talking about buying the PBM, which also owns the pharmacies.

The vertical integration and lack of competition is something. And then they can hide it all throughout that vertical integration. They don't care where they make it, as long as they make it. But that is the problem. You hit the nail on the head right there.

Anything else you want to add to that?

Ms. KING. I just want, I just want to pile on. So, I —

Mr. CARTER. Sure.

Ms. KING. I think that in some instances we're seeing integration and it's not just vertical; right? We're seeing horizontal integration. We're seeing vertical integration. And now we're also starting to see cross-market integration where hospitals are buying provider systems in other parts of the state, other, and in other states. And the more integrated these markets become overall, the less competition we are able to have.

Mr. CARTER. And that is the whole key. Transparency is eminently important, no question about it. But competition is the key as well. And being able to see that competition, we have used the example about buying a car. I believe it is New Hampshire who has a database, a website you can go to to compare medical costs. That is the kind of thing we are talking about, and that is what is going to lead to decreasing healthcare costs.

Ms. KING. Well, that's right. And if there's very little competition in the state, or you have an entity with an extreme amount of market power, they are able to keep prices very high, regardless of how transparent you make them.

Mr. CARTER. Right.

Ms. KING. If you don't have a choice of where to go, they can charge you whatever they want.

Mr. CARTER. OK. Let me get to my part. First of all, Mr. Chairman, I want to ask unanimous consent to submit two letters, one

from the National Community Pharmacists Association and another from the American Pharmacists Association for the record.

Mr. HARPER. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. CARTER. Thank you very much.

I need to get back very quickly to a question that Representative Barton asked about the coupons being used in Medicare Part D. The anti-kickback, as you know, that will prohibit that from happening. But one thing my colleagues need to keep in mind is that a lot, most of these coupons are for brand name drugs. And if you get outside of that formulary it is going to end up costing taxpayer more.

And every quickly, the reason that happens is because when a patient goes and meets their deductible, then goes into the donut, if they increase the costs by buying the ones that are off the formulary then they get into the catastrophic quickly, more quickly, which means that the taxpayers are going to be paying more for their insurance, for that patient's insurance. It is going to end up actually costing taxpayers more.

So that is one of the reasons why the Medicare Part D CMS does not allow that to happen in there. So I want to make sure we got that clear.

Representative Griffith mentioned my legislation dealing with gag clauses. Twenty-two states have implemented this thus far. We need to implement it at the Federal level. Here we are in America with freedom of speech, and over 30 years of experience in working in pharmacy and I could never tell a patient, look, if you pay for this out of your pocket it will only cost you \$7.00, but your copay is going to be \$20.00. And that is just ridiculous for us, particularly here in America, not to be able to do that.

I wanted to talk also about PBMs and their licensure and registration. A number of states have required PBMs to register with their insurance commissions. And the most recent one was Arkansas held a special session. And now they have enacted the Arkansas Pharmacy Benefit Licensure Act where the state insurance department requires PBMs to license within the state.

One of the things, also, we talk about pharmacies. The number one pharmacy in America, CVS, they have more stores. Walgreens. You know what number three is? Express Scripts with their mail order pharmacies. Yet, they do not have to register in each state.

Don't you think they should at least have to register in each state, the third largest pharmacy chain in America? And they are nothing but mail order pharmacies. Surely they should have to register in every state.

Any comment.

Ms. KING. I know very little about it but it sounds like you're right, yes.

Mr. CARTER. OK. I know.

So, anyway, Dr. King, Medicaid managed care organizations, that is another way that we can attack some of these costs as well because without having, without having the transparency there to see what exactly the PBMs are charging in those, then we are unable to control costs.

In fact, West Virginia just did away with their managed—they carved that out and saved \$30 million. In Ohio they saved \$227 million. In Kentucky they figured their costs would be \$380 million. Why can't we control that on a Federal level as well?

We have a number of managed care organization contracts at the Federal level. If we could control those, do you think we could have—and had transparency in it, do you think we could save costs there?

We could. The answer is yes. I'm sorry.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlewoman from Illinois, Ms. Schakowsky, for 5 minutes.

Ms. SCHAKOWSKY. Thank you.

Dr. Chernew, I have never heard a witness, though I am sure many are thinking of it, that I wish my time were over. And I have been chuckling over that for most of the hearing.

You mentioned the idea that pharmaceutical companies, manufacturers can charge whatever the market will bear. But the question is, what is the market?

We have a briefing from a Dr. Anderson from Hopkins who said, for example, Sovaldi, that they decided that all they really needed to make back the money that they invested in Sovaldi, or the marketing that they do, they need 20 percent of the market.

So, we are not talking about widgets, we are not talking about cars, we are talking about illness, life, death. And so if they charge, which they did, \$86,000 for this cure to Hep C, all they really care about is that if 20 percent of people who have this really awful disease can get cured.

And so it seems to me that we ought to have a better way. When you say charge whatever they want to make the money they want, this isn't about free markets, this is about a very segmented market. I just wonder if you would comment on that?

Mr. CHERNEW. I wrote in my written testimony that I was going to avoid pharmaceutical markets because it raises so many complicated issues. But since asked, I will dip my toe in.

The challenge, and I will use Sovaldi as an example, is Sovaldi was a truly innovative drug. And all analyses suggest at least most any value criteria you would have. And although it may be difficult for people to swallow—that's not a pill joke—but anyway, it turns out that the evidence suggests that with greater incentives for prescription drug innovation you get more innovation.

The problem is that statement should not imply that the drug companies get a blank check. And therein lies the basic problem.

I do not think their goal was simply to make back their R&D money. Their goal was to make more money.

Ms. SCHAKOWSKY. Yes.

Mr. CHERNEW. Right? That's the goal in capitalist societies, to make more money. And in fact they have created a remarkably good product that for decades will benefit us and everybody. Right?

Ms. SCHAKOWSKY. Not everybody.

Mr. CHERNEW. The challenge—

Ms. SCHAKOWSKY. The people who can pay for it.

Mr. CHERNEW. No, that's right. So the people who can't pay for it and don't get it, they're in the same place off they were before

it got invented. So, the challenge is how to manage the incentives for innovation, which are really important, with the obvious egregious problems of pricing. Not simply for what people who pay out of pocket. It's the out-of-pocket comments that bring everybody here. But the charge, to deal with the overall total amount of spending, and the prices, and the volume for all of these drugs.

Ms. SCHAKOWSKY. You know what, let me stop because I have one more—

Mr. CHERNEW. Thank you.

Ms. SCHAKOWSKY [continuing]. One more question about it.

But I think it is worse if you know that there is the cure right there, that there is a cure right there and you can't get it. I think in some ways it is worse than thinking there isn't one.

But, again, about—OK, so you don't want to talk about markets, but I just want to mention this. One argument is that increased competition or more generic drugs are going to lead to lower drug prices. But recently Elizabeth Rosenthal described the bizarre phenomenon economists call sticky pricing where prices of competing prescription drugs simply rise together with each new drug that is provided.

So, we have got Novartis, a cancer drug. And Gleevec was first listed at \$26,000 in the market. And the first generic was list priced at around \$140,000 annually. And now many drugs in the same family as Gleevec cost on average \$150,000 per year.

So, we aren't seeing. Again, markets in drugs, very different. We are seeing an increase. So, this thought that competition is going to drive it down and generics will drive it down, not working always.

Mr. CHERNEW. Always. I agree.

So, if you look at drugs at 15 years ago we could have been arguing about Lipitor and a whole series of other blockbuster drugs. They've all gone generic. We buy them at Harvard, they're bought as generic. It's a great deal. And there's a lot of real advances.

The challenges that are presented through some of those drugs, through biosimilars, which is a whole different issue, becomes important, are really, really, really important. And the issues you're raising I'm incredibly sympathetic with because the basic problem is we've been very successful at encouraging amazing innovation.

We haven't found a good way to make sure that that innovation is affordable for people. And even if you solve the problem that people are paying a lot out of pocket, the prices getting passed through through insurance premiums create a really fundamental challenge.

Ms. SCHAKOWSKY. OK, but I just want—and I know my time is up—but we are seeing increases in drugs that have been on the market for decades. They charge what the market will bear, and that means that the prices have kept going up out of control.

So, I can't let you answer. I am sorry, I am out of time. And you should be happy.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from Pennsylvania, Mr. Costello, for 5 minutes.

Mr. COSTELLO. Thank you, Mr. Chairman.

Dr. Chernew, in your written testimony you noted that one of the many reasons that many transparency initiatives have had only a minimal impact on the market is because consolidation in the healthcare markets limits choice. Consolidation in the healthcare industry is something that is of great interest to this committee. As Chairman Harper mentioned at the beginning of the hearing, the O&I Subcommittee had a hearing on consolidation in the healthcare market last February.

Do you think that there has been too much consolidation in the healthcare market? And, if so, what impact has it had on healthcare costs?

Second piece of the question, how does consolidation limit the effectiveness of both private and public transparency initiatives?

Mr. CHERNEW. Yes, there's too much consolidation and it's raised the prices and spending.

And the consolidation makes it difficult for transparency initiatives to work because they fundamentally require choice. If there's no choice, knowing the price of an office charge doesn't help you all that much.

The only thing I will say is don't think about transparency as only working through consumers. Having the regulators, having the policy commission, having journalists see the prices can also be helpful. But by and large the more consolidation, the harder it is to get markets to work and, therefore, the harder it is to get transparency to work.

Mr. COSTELLO. I have a question for you. But would you like anything to add, Dr. King? You were shaking your head yes before.

Ms. KING. Yes. Well, I'm in vehement agreement with most of the things he has said today.

So, I think that also transparency can help with the consolidation problem because you can actually, if you have a good All Payer Claims Database you can look and see how a particular merger or acquisition over time drove up costs or didn't drive up costs.

Did they actually gain the efficiencies they said they were going to get when they actually merged?

Did they pass it through to consumers? You'd be able to know that. And you'd be able to then turn around and stop future consolidation in the markets through that.

So, I think that those work both ways.

Mr. COSTELLO. Dr. King, thank you. In your written testimony you highlighted how states could use healthcare claims data reported to an APCD to examine the drivers of healthcare costs over time, the impact of mergers, acquisitions, and other affiliations on healthcare price and quality, among other things, similar to what you just were sharing with us right there.

How would the healthcare claims data reported to an APCD give states with an APCD unique insight into the impact of M&As that states without an APCD would not have?

Ms. KING. So, currently because a lot of these private prices are shrouded in secrecy, the attorney general doesn't know and other state entities don't actually have the data to examine how mergers in the past have affected prices, or they don't have the ability to project how mergers in the future might affect prices.

And so, if you have this enormous database of healthcare prices over time that allows you to look at utilization patterns, how people went, were funneled to different providers, and the cost, you could then make much better economic projections about how a merger might affect things in the future. And, also, you'd be able to look back in the past and see if they kept their promise.

Mr. COSTELLO. Can you describe the general approaches states have been taking regarding the pharmaceutical price transparency bills you have seen?

Ms. KING. Yes. So, states have looked at a number of different things with regard to price to pharmaceuticals this year. This has been the big topic among the states. They have done everything from a lot of price, pharmaceutical price disclosure anti-gag clauses this year.

They have also looked at pricing reports or requiring pharmaceutical companies to submit reports at the end of the year, annually or at some other time that basically describe how much it cost them to produce a drug, what they spent on development and marketing, and then what, how they're pricing their drugs, both as an annual cost, as an individual patient cost.

States have also focused on gag prohibitions and disclosures, pricing reports. And that's a lot of what we've seen with respect to pharmaceuticals. And then a lot of PBM regulation as well, trying to promote transparency amongst the pharmacy benefit managers.

Mr. COSTELLO. Thank you. I will yield back.

Mr. HARPER. The gentleman yields back.

I want to thank both of you for being here today, giving us some very valuable insight and information as we tackle this very important challenge that we have.

So, I want to thank the members that have participated in today's hearing. And I will remind members that they have 10 business days to submit questions for the record. And should you receive any written questions, we would ask the witnesses to respond as quickly as possible to those questions.

The subcommittee is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

July 15, 2018

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled “Examining State Efforts to Improve Transparency of Health Care Costs for Consumers.”

The Subcommittee on Oversight and Investigations will hold a hearing on Tuesday, July 17, 2018, at 10:15 a.m. in 2322 Rayburn House Office Building, entitled “Examining State Efforts to Improve Transparency of Health Care Costs for Consumers.” The purpose of the hearing is to examine state laws and policies that improve transparency of health care costs for consumers and the impact that they had on consumers.

I. WITNESSES

- Jaime King, Professor, UC Hastings College of the Law, Associate Dean and Co-Director, UCSF/UC Hastings Consortium on Law, Science, and Health Policy;
- Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy, Director, Healthcare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School; and
- Kavita Patel, Associate Chief Medical Officer, Johns Hopkins Medicine.

II. BACKGROUND

A. Health Care Expenditures

In 2016, U.S health care spending was estimated to be about \$3.3 trillion, and the overall share of gross domestic product (GDP) related to health care spending was 17.9 percent (up from 17.7 percent in 2015).¹ According to the Centers for Medicare and Medicaid Services (CMS), 32 percent of the \$3.3 trillion in expenditures was spent on hospital care, 20 percent was spent on physician and clinical services, 14 percent was spent on other (including, but not limited to home health care and durable medical equipment), 10 percent was spent on prescription drugs, 8 percent was spent on government administration and net cost of health insurance, 5 percent was spent on nursing care facilities and continuing care retirement communities, 5 percent was spent

¹ U.S. Dep’t of Health and Human Services, Centers for Medicare & Medicaid Services, *National Health Expenditures 2016 Highlights* (Dec. 2017), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

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on investment, and 4 percent was spent on dental services.² The majority—75 percent—of the \$3.3 trillion in expenditures was paid for by health insurance (34 percent by private health insurance, 20 percent by Medicare, 17 percent by Medicaid, and 4 percent by the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense (DOD), and the Children’s Health Insurance Program (CHIP)).³

According to a Kaiser Family Foundation analysis of National Health Expenditure data released by CMS, total health expenditures have increased substantially over the past several decades.⁴ Indeed, data released by CMS indicates that total health expenditures in the U.S. were about \$721 billion in 1990, \$1.4 trillion in 2000, \$2.4 trillion in 2008, and \$3.3 trillion in 2016.⁵ Moreover, on a per capita basis, health spending has also grown—increasing from \$8,412 in 2010 to \$10,348 in 2016.⁶ Although health care expenditures have continued to increase at a rapid pace, U.S. health care spending increased in 2016 at a slower rate than in previous years (in 2016, spending on health care increased by 4.3 percent compared to 5.1 percent in 2014 and 5.8 percent in 2015).⁷

Many different factors may influence health care spending, including, but not limited to, population aging, prices, policy changes, consolidation, and public and private initiatives.⁸ Moreover, some research has shown that there may be significant variation in the cost of health care services in one geographic region, and that more expensive health care services are not always associated with a higher quality of care.⁹ For example, a 2014 study by the U.S. Government Accountability Office (GAO), found that “the estimated total cost of maternity care at selected acute care hospitals in the Boston area that rated more highly on several quality indicators ranged between \$6,834 and \$21,554 (consumers would pay between \$2,967 and

² U.S. Dep’t of Health and Human Services, Centers for Medicare & Medicaid Services, *The Nation’s Health Dollar (\$3.3 Trillion), Calendar Year 2016: Where it Came From, Where it Went* (Dec. 2017), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/PieChartSourcesExpenditures.pdf>.

³ *Id.*

⁴ Rabah Kamal and Cynthia Cox, Peterson-Kaiser Health System Tracker, *How has U.S. spending on health care changed over time?* (Dec. 20, 2017), available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-total-health-expenditures-increased-substantially-past-several-decades_2017.

⁵ *Id.*

⁶ *Id.*

⁷ Micah Hartman, et al., *National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions*, HEALTH AFFAIRS, Vol. 37, No. 1 (Dec. 6, 2017), available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1299>.

⁸ Aaron C. Catlin and Cathy A. Cowan, *History of Health Spending in the United States, 1960-2013* (Nov. 19, 2015), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf>; Sean P. Keehan, et al., *National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy*, HEALTH AFFAIRS (Mar. 2017), available at [https://www.ssc.wisc.edu/~gwallace/Papers/Health%20Aff-2017-Keehan-hlthaff.2016.1627%20\(1\).pdf](https://www.ssc.wisc.edu/~gwallace/Papers/Health%20Aff-2017-Keehan-hlthaff.2016.1627%20(1).pdf); Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 10: Provider Consolidation: The Role of Medicare Policy* (June 2017).

⁹ U.S. Government Accountability Office (GAO), *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11, at 11 (Oct. 20, 2014).

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\$5,000 in estimated out-of-pocket costs).¹⁰ Similarly, in Massachusetts, the median price of magnetic resonance imaging (MRI) of the spine ranges from \$500 to \$1,670.¹¹

Consumers are increasingly responsible for more of their health care costs. According to CMS, in 2016, consumers directly paid for about 11 percent of the \$3.3 trillion spent on health care and out-of-pocket spending grew at the fastest rate of growth in 2016 since 2007.¹² In an April 2018 report, America's Health Insurance Plans (AHIP) indicated that the number of individuals enrolled in Health Savings Account (HSA)-Qualified High Deductible Health Plans (HDHPs) has been increasing, and that as of January 2017, 52 health insurance providers reported that over 21.8 million people were enrolled in an HSA-Qualified HDHP.¹³ This is a significant increase over the approximately 10 million individuals enrolled in an HSA-Qualified HDHP in 2010.

B. Health Care Price Transparency Efforts

i. Overview

As consumers pay more for their health care, there has been an increasing amount of discussion about the role of health care price transparency for consumers and the importance of providing consumers with information that enables them to make informed health care decisions.¹⁴ Some experts have reasoned that providing patients with information about health care costs may help reduce spending and improve care by empowering patients to make informed health care decisions.¹⁵ Other experts, however, have questioned whether some of the

¹⁰ *Id.* at 12.

¹¹ Ateev Mehrotra, M.D., M.P.H., Michael E. Chernew, Ph.D., and Anna D. Sinaiko, Ph.D., *Promise and Reality of Price Transparency*, THE NEW ENGLAND JOURNAL OF MEDICINE, at 1348 (Apr. 8, 2018); See also Zack Cooper, et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, HEALTH CARE PRICING PROJECT, at 21 (May 8, 2018), available at http://www.healthcarepricingproject.org/sites/default/files/20180507_variationmanuscript_0.pdf.

¹² U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, *National Health Expenditures 2016 Highlights* (Dec. 2017), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>; U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, *The Nation's Health Dollar (\$3.3 Trillion), Calendar Year 2016: Where it Came From, Where it Went* (Dec. 2017), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/PieChartSourcesExpenditures.pdf>.

¹³ America's Health Insurance Plans (AHIP), *Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools*, at 3 (Apr. 2018), available at https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf.

¹⁴ See, e.g., U.S. Government Accountability Office (GAO), *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11, at 1 (Oct. 20, 2014).

¹⁵ See, e.g., Robert Wood Johnson Foundation, *How Price Transparency Can Control the Cost of Health Care*, Health Policy Snapshot Series (Mar. 1, 2016), available at <https://www.rwjf.org/en/library/research/2016/03/how-price-transparency-controls-health-care-cost.html>; Health Care Cost Institute, *Issue Brief: Spending on Shoppable Services in Health Care* (Mar. 2016), available at http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf; Chapin White, et al., *Policy Analysis: Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending* (May 2014), available at <http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf>; Bobbi Coluni, *White Paper: Save \$36 Billion in U.S. Healthcare Spending Through Price Transparency*, Thomson Reuters (Feb. 2012), available at http://64.64.16.103/wp-content/uploads/2012/09/thomsonreuters_savings_from_price_transparency.pdf.

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current efforts to engage patients and provide them with information about the costs of health care services have successfully lowered health care expenditures and encouraged price shopping.¹⁶ Recently, the Secretary of the Department of Health and Human Services (HHS), Alex Azar, highlighted the potential value of price transparency.¹⁷ Azar said that “if we want to move to a system where we put patients more in charge of their own healthcare dollars, providers and insurers have to become more transparent about their pricing. There is no more powerful force than an informed consumer.”¹⁸

Many states have taken steps to improve price transparency in the health care market and lower health care costs. These transparency efforts have generally attempted to provide consumers with information about different types of health care costs, including, but not limited to, information about the cost of health care services and/or the cost of prescription drugs. The state initiatives encouraging more transparency on prescription drug costs have taken a variety of different approaches, including, but not limited to, requiring drug manufacturers to submit information about price increases, requiring drug manufacturers to report information regarding the prices of prescription drugs and the costs associated with developing and marketing them, and prohibiting “gag clauses” that restrict pharmacists from disclosing price options to customers.¹⁹ According to the National Conference of State Legislatures (NCSL), 22 states enacted laws between 2016 and May 31, 2018, prohibiting “gag clauses” in contracts that prohibit pharmacies from telling consumers about alternative pricing options for prescription drugs.²⁰

Similarly, state efforts to promote price transparency for the cost of health care services have also varied in approach. For instance, some state efforts have required that providers report certain pricing information to the state or the patient while other efforts have required that insurers submit certain pricing information.²¹ Likewise, some state initiatives have required that pricing information be publicly posted while other initiatives have required that the information be given to the individual patient before they receive medical care.²² Sections II.B.ii and II.B.iii of this memorandum provide a non-exhaustive list of examples of health care transparency tools

¹⁶ See, e.g., Sunita Desai, et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, JAMA (May 3, 2016), available at <https://jamanetwork.com/journals/jama/fullarticle/2518264>.

¹⁷ Alex M. Azar II, *Remarks on Value-Based Transformation to the Federation of American Hospitals* (Mar. 5, 2018), available at <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html>.

¹⁸ *Id.*

¹⁹ National Conference of State Legislatures, Prescription Drug Resource Center, *Recent Approaches in State Prescription Drug Laws* (Apr. 4, 2018), available at <https://kaiserhealthnews.files.wordpress.com/2018/04/recent-approaches-in-state-prescription-drug-laws-discussion-march-2018-002.pdf>; National Conference of State Legislatures, Prescription Drug Resource Center, *Prohibiting PBM “Gag Clauses” that Restrict Pharmacists from Disclosing Price Options: Recent State Legislation 2016-2018* (Jun. 1, 2018), available at http://www.ncsl.org/Portals/1/Documents/Health/Pharmacist_Gag_clauses-2018-14523.pdf.

²⁰ National Conference of State Legislatures, Prescription Drug Resource Center, *Prohibiting PBM “Gag Clauses” that Restrict Pharmacists from Disclosing Price Options: Recent State Legislation 2016-2018* (Jun. 1, 2018), available at http://www.ncsl.org/Portals/1/Documents/Health/Pharmacist_Gag_clauses-2018-14523.pdf.

²¹ National Conference of State Legislatures, *Transparency and Disclosure of Health Costs and Provider Statements: State Actions* (last updated Mar. 2017), available at <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx>.

²² Ateev Mehrotra, M.D., M.P.H., Michael E. Chernew, Ph.D., and Anna D. Sinaiko, Ph.D., *Promise and Reality of Price Transparency*, THE NEW ENGLAND JOURNAL OF MEDICINE, at 1348-49 (Apr. 8, 2018).

adopted by the states and other stakeholders that help inform patients about the costs of health care services.

As some of these transparency initiatives have been discussed and implemented, many stakeholders have highlighted the importance of considering several factors to ensure that, when a transparency tool is adopted, it conveys health care cost information to consumers in a meaningful way. For example, in 2014, the Healthcare Financial Management Association (HFMA) issued a report entitled “Price Transparency in Health Care” outlining five principles for the development of price transparency tools.²³ These principles include, among other things, that “price transparency should empower patients and other care purchasers to make meaningful price comparisons prior to receiving care,” and “that price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.”²⁴ Similarly, in an October 2014 report, GAO noted that “[t]ransparency tools are most effective if they provide information relevant to consumers and convey information in a way that consumers can readily understand” and identified 15 characteristics of effective transparency tools.²⁵ Moreover, one economist at the Kellogg School of Management at Northwestern University recently found that health care consumers will price shop, but only if the information is conveyed in a simple, and understandable manner.²⁶

Some of the factors that make it difficult to convey price information to consumers in a meaningful way includes, but is not limited to, the fact that: (1) price information is oftentimes most useful for insured customers if it includes specific information about their particular insurance coverage;²⁷ (2) each patient has unique circumstances that may change the cost of their care;²⁸ (3) billing for health care services is complex;²⁹ (4) price information may be more useful to consumers if it also provides them with information about quality;³⁰ (5) according to one study, less than seven percent of out-of-pocket spending was spent on shoppable health care services;³¹ and (6) transparency might be most effective if it is combined with other incentives or benefit designs that encourage consumers to price shop.³² Section II.B.iv of this memorandum

²³ Healthcare Financial Management Association (HFMA), *Price Transparency in Health Care, Report from the HFMA Price Transparency Task Force* (2014), available at <https://www.hfma.org/transparency/>.

²⁴ *Id.*

²⁵ U.S. Government Accountability Office (GAO), *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11, at 11 (Oct. 20, 2014).

²⁶ Kellogg Insight, *Will People Price Shop for Healthcare?* (Jan. 4, 2018), available at <https://insight.kellogg.northwestern.edu/article/will-people-price-shop-for-healthcare>.

²⁷ U.S. Government Accountability Office (GAO), *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11, at 11 (Oct. 20, 2014).

²⁸ Public Agenda, *Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas, and New Hampshire* (2017), available at https://www.publicagenda.org/files/PublicAgenda_StillSearching_2017.pdf.

²⁹ Matt Kuhrt, *Report: This is the biggest barrier to consumer price shopping in healthcare*, FIERCEHEALTHCARE (Apr. 11, 2018), available at <https://www.fiercehealthcare.com/hospitals-health-systems/report-finds-barriers-to-use-price-transparency-tools>.

³⁰ Francois de Brantes, et al., *Price Transparency & Physician Quality Report Card 2017*, ALTARUM AND CATALYST FOR PAYMENT REFORM (2017).

³¹ Health Care Cost Institute (HCCI), *Issue Brief: Spending on Shoppable Services in Health Care* (Mar. 2016), available at http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf.

³² See, e.g., Sunita Desai, et al., *Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, HEALTH AFFAIRS 36:8 (Aug. 2017).

discusses some of these barriers to effective price transparency tools in more detail and highlights some of the recent evidence suggesting that many price transparency initiatives have not been associated with decreased spending.³³

ii. State Efforts to Promote Transparency of the Cost of Health Care Services for Consumers

As previously mentioned, there are a lot of initiatives at the state level to make the price of health care services available to consumers. For illustrative purposes, below is a non-exhaustive list of some of these efforts.

- **New Hampshire:** New Hampshire has adopted robust price transparency policies. New Hampshire created an All-Payer Claims Database (APCD)³⁴ in 2003 to collect and disseminate information about health care prices.³⁵ Four years later, in 2007, New Hampshire launched a public website, NHHealthCost.org, that originally provided the median bundled prices for about thirty of the most common health care services.³⁶ Today, NHHealthCost.org has been expanded to provide consumers with information for over 100 services and provides information about specific providers that can be customized to include information about the individual's specific health plan.³⁷ The website also includes certain quality information.³⁸ Additional information about New Hampshire's website and the methodology used for health costs is available on NHHealthCost.org.³⁹ On July 12, the New Hampshire Insurance Department announced that it was partnering with Harvard Medical School to help New Hampshire residents find medical cost estimates.⁴⁰ In the press release, the President and CEO of the Greater Manchester Chamber of Commerce commented that "NHHealthCost.org gives employers a way to share information on the differences in healthcare costs and quality. It also offers resources for large and small employers to help them evaluate the value of their

³³ Ateev Mehrotra, M.D., M.P.H., Michael E. Chernew, Ph.D, and Anna D. Sinaiko, Ph.D., *Promise and Reality of Price Transparency*, THE NEW ENGLAND JOURNAL OF MEDICINE (Apr. 8, 2018).

³⁴ Additional information about All-Payer Claims Databases (APCDs) and how they are used to provide consumers with price information is available on a website created by the APCD Council. See APCD Council, *APCD Showcase* (last visited Jul. 12, 2018), available at <https://www.apcdshowcase.org>.

³⁵ The Source on Healthcare Price & Competition, New Hampshire (last visited Jul. 12, 2018), available at <http://sourceonhealthcare.org/new-hampshire/>.

³⁶ *Id.*

³⁷ Ateev Mehrotra, M.D., M.P.H., Michael E. Chernew, Ph.D, and Anna D. Sinaiko, Ph.D., *Promise and Reality of Price Transparency*, THE NEW ENGLAND JOURNAL OF MEDICINE (Apr. 8, 2018); New Hampshire Insurance Department, *NH HealthCost* (last visited Jul. 12, 2018), available at <https://nhhealthcost.nh.gov/costs/medical/step-2/?carrier=uninsured#filter-control>.

³⁸ New Hampshire Insurance Department, *NH HealthCost* (last visited Jul. 12, 2018), available at <https://nhhealthcost.nh.gov/costs/medical/step-2/?carrier=uninsured#filter-control>.

³⁹ See New Hampshire Insurance Department, *Methodology for Health Costs for Consumers* (Jul. 12, 2018), available at <https://nhhealthcost.nh.gov/methodology-health-costs-consumers>.

⁴⁰ New Hampshire Insurance Department, *NH Insurance Department Partners with Harvard Medical School to Help NH Residents Find Medical Cost Estimates* (Jul. 12, 2018), available at <https://www.nh.gov/insurance/media/pr/2018/documents/07-12-18-nh-healthcost-updates-harvard-press-release.pdf>.

investments in health benefits.”⁴¹ New Hampshire also requires that health insurers provide their members with price information.⁴²

- **Massachusetts:** Massachusetts has introduced several bills to improve transparency.⁴³ One of the price transparency initiatives in Massachusetts was the development of a website that provides consumers with certain information about pricing of different health care services, quality information, and other resources such as suggested questions to ask about health care.⁴⁴ The website, MassCompareCare.gov, provides information about the total amount that was paid to the provider for certain services, and allows consumers to compare the costs of medical procedures in different health care facilities.⁴⁵ It provides information about the cost of nearly 300 common medical services and procedures.⁴⁶ The website also directs consumers to their insurance plan to learn what the procedure will cost them.⁴⁷ Under the Massachusetts Healthcare Cost Containment and Quality Improvement law, passed in 2012, all health insurers in Massachusetts are required to provide members with cost estimates online.⁴⁸ Recently, Massachusetts announced that it plans to release all of the data it uses to support its website as a single dataset on July 20, 2018, and, at that time, will also launch a transparency data challenge to promote innovative uses of the data.⁴⁹
- **Ohio:** In 2015, Ohio passed a law requiring providers to give patients a “good faith” estimate of how much non-emergency, elective health care services would cost individuals after accounting for insurance.⁵⁰ Due to ongoing litigation, the law has not yet been implemented.⁵¹

⁴¹ *Id.*

⁴² National Conference of State Legislatures, *Transparency and Disclosure of Health Costs and Provider Payments: State Actions* (last updated Mar. 2017), available at <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx>.

⁴³ The Source on Healthcare Price & Competition, *Massachusetts* (last visited Jul. 12, 2018), available at <http://sourceonhealthcare.org/massachusetts/>.

⁴⁴ Commonwealth of Massachusetts, *CompareCare* (last visited Jul. 12, 2017), available at <https://masscomparecare.gov/>.

⁴⁵ Commonwealth of Massachusetts, *About CompareCare* (last visited Jul. 12, 2017), <https://masscomparecare.gov/about>.

⁴⁶ Priyanka Dayal McCulskey, *What consumers need to know about the state's new health care website*, THE BOSTON GLOBE (May 16, 2018), available at <https://www.bostonglobe.com/metro/2018/05/15/what-consumers-need-know-about-state-new-health-care-website/n9XGrgu1VtN4mhJQqc8PFL/story.html>.

⁴⁷ Commonwealth of Massachusetts, *CompareCare* (last visited Jul. 12, 2017), available at <https://masscomparecare.gov/>.

⁴⁸ Mass.gov, Mass Consumer Affairs Blog, *Massachusetts Health Insurers Now Required to Provide Prices in Real-Time* (Oct. 1, 2014), available at <https://blog.mass.gov/consumer/massconsumer/massachusetts-health-insurers-now-required-to-provide-prices-in-real-time/>.

⁴⁹ Center for Health Information and Analysis (CHIA), *Strategy for Releasing Procedure Price Data* (Jun. 2018), available at <http://www.chiamass.gov/assets/Uploads/Strategy-for-Releasing-Procedure-Pricing-Data.pdf>.

⁵⁰ The Source on Healthcare Price & Competition, *Ohio* (last visited Jul. 12, 2018), available at <http://sourceonhealthcare.org/ohio/>.

⁵¹ *Id.*

- **Colorado:** Colorado has passed many proposals to promote price transparency.⁵² One of the recent initiatives passed by Colorado requires that hospitals and certain other provider groups to post their private-pay, non-discounted fees on their websites, or make them available upon request, for the most common health care services that they provide.⁵³
- **Illinois:** Illinois has implemented several policies to promote price transparency.⁵⁴ One of the laws passed in Illinois requires that hospitals give prospective patients estimated costs of services before treatment.⁵⁵

Again, the above list is just a sampling of some of the state initiatives. For example, other states with health care price transparency websites include, but are not limited to, Oregon,⁵⁶ Maine,⁵⁷ Maryland,⁵⁸ and Washington.⁵⁹ While there have been several state initiatives targeted at price transparency, an annual report card released by the Catalyst for Payment Reform and Altarum's Center for Payment Innovation still gives most states a failing grade.⁶⁰ Indeed, in the 2017 report card, only two states—Maine and New Hampshire—received an “A” for transparency, only two states—Maryland and Oregon—received a “B” for transparency, and only three states—Colorado, Vermont, and Virginia—received a “C” for transparency. The other 43 states received an “F” for transparency.⁶¹ According to the organizations, “states with high price transparency grades have rich data sources and supply meaningful price information on a wide range of procedures and services that is presented on an accessible, publicly available website.”⁶²

States have encountered a lot of different barriers while trying to adopt some of these transparency initiatives. For example, many of the state transparency websites utilize information from the state's All-Payer Claims Databases (APCDs) to help facilitate price shopping, and there have been a number of implementation challenges for APCDs including

⁵² The Source on Healthcare Price & Competition, *Colorado* (last visited Jul. 12, 2018), available at <http://sourceonhealthcare.org/legislation-regulation/colorado/>.

⁵³ Colorado General Assembly, *SB17-065: Transparency in Direct Pay Health Care Prices* (2017), available at <https://leg.colorado.gov/bills/sb17-065>; See also Richard Mark Kirkner, *If You Make Them Build It, They Still May Not Come*, MANAGED CARE (Jun. 3, 2018), available at <https://www.managedcaremag.com/archives/2018/6/if-you-make-them-build-it-they-still-may-not-come>.

⁵⁴ The Source on Healthcare Price & Competition, *Illinois* (last visited Jul. 12, 2018), available at <http://sourceonhealthcare.org/illinois/>.

⁵⁵ National Conference of State Legislatures, *Transparency and Disclosure of Health Costs and Provider Statements: State Actions* (last updated Mar. 2017), available at <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx>.

⁵⁶ OregonHospitalGuide.org (last visited Jul. 12, 2018), available at <http://oregonhospitalguide.org/>.

⁵⁷ CompareMaine.org (last visited Jul. 12, 2018), available at <http://www.comparemaine.org>.

⁵⁸ Maryland Health Care Commission, *Wear the Cost* (last visited Jul. 12, 2018), available at <http://wearthecost.org>; See also Robert E. Moffitt, Ph.D., et al., *The Next Chapter In Transparency: Maryland's Wear the Cost*, THE HERITAGE FOUNDATION (Oct. 19, 2017), available at <https://www.heritage.org/health-care-reform/commentary/the-next-chapter-transparency-marylands-wear-the-cost>.

⁵⁹ Washington HealthCareCompare (last visited Jul. 12, 2018), available at <https://www.wahealthcarecompare.com>.

⁶⁰ In 2017, the Catalyst for Payment Reform and Altarum's Center for Payment Innovation issued a report card that combined price transparency and quality information in one report card. Francois de Brantes, et al., *Price Transparency & Physician Quality Report Card 2017*, ALTARUM AND CATALYST FOR PAYMENT REFORM (2017).

⁶¹ *Id.*

⁶² *Id.* at 3.

issues relating to: (1) concerns with data privacy and security; (2) concerns with the accuracy and integrity of the data that is submitted and whether the data conveys information in an accurate manner; (3) concerns with the comprehensiveness of the data submitted to the APCD; (4) concerns regarding whether the release of negotiated price information could violate state and federal antitrust laws and lead to collusion; (5) concerns that the requested information is confidential information pursuant to specific contractual provisions or is subject to trade secret protection; and (6) concerns with the administrative cost to comply with some of the requirements.⁶³

iii. Other Price Transparency Tools that are Available to Promote Transparency of Health Care Services for Consumers

The private sector has also pursued a lot of different transparency efforts to help inform consumers of the price of health care services. Nearly all insurers provide their members with access to a health care cost transparency tool.⁶⁴ Many employers—at least 85 percent of self-insured employers according to one report—also use vendors such as Castlight Health and Truven Health Analytics to provide health care price transparency tools to employees.⁶⁵ According to a poll conducted by one of these vendors, Truven, 80 percent of the individuals who used the tool and were surveyed said that the cost transparency tool “helped them understand their financial responsibility up front.”⁶⁶ Similarly, some hospitals and other providers have developed health care price transparency tools for patients.⁶⁷

C. Role and Impact of Health Care Price Transparency

As previously mentioned, there has been an increasing amount of interest in the role of price transparency, especially as consumers are directly responsible for more of their health care costs.⁶⁸ Patients generally want to know how much health care services will cost. A report released by Public Agenda in 2017 found that about 50 percent of Americans have tried to find health care price information before obtaining care and about 20 percent of individuals have tried to compare provider prices.⁶⁹ A report released by the Foundation for Government Accountability (FGA) found that 77 percent of Americans want the “Right to Shop” in health

⁶³ The Source on Healthcare Price & Competition, *Healthcare Legislative Topics: All Payer Claims Databases*, MEDIUM (Apr. 3, 2015), available at <https://medium.com/@SourceOnHealth/healthcare-legislative-topics-all-payer-claims-databases-6f87b24c7fcf>.

⁶⁴ Shelby Livingston, *Is the price right? Solving healthcare's transparency problem*, MODERN HEALTHCARE (last visited Jul. 12, 2018), available at <http://www.modernhealthcare.com/reports/achieving-transparency-in-healthcare/#/>.

⁶⁵ *Id.*

⁶⁶ Truven Health Analytics, *The Value of Price Transparency in Healthcare* (last visited Jul. 14, 2018), available at http://img.en25.com/Web/TruvenHealthAnalytics/Price_Transparency_Infographic_FINAL.pdf.

⁶⁷ See, e.g., Harris Meyer, Hospitals roll out online price estimators as CMS presses for transparency, MODERN HEALTHCARE (Jun. 23, 2018), available at <http://www.modernhealthcare.com/article/20180623/NEWS/180629994>.

⁶⁸ See, e.g., U.S. Government Accountability Office (GAO), *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11, at 1 (Oct. 20, 2014).

⁶⁹ Public Agenda, *Still Searching: How People Use Health Care Price Information in the United States*, New York State, Florida, Texas, and New Hampshire (Apr. 2017).

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care.⁷⁰ Having access to price and quality information can help enable patients identify lower cost and high quality care.⁷¹

While these reports showed that many patients want to know the cost of their health care services, some other studies have raised concerns about how, if at all, consumers use some of the available price transparency tools.⁷² In April 2018, the *New England Journal of Medicine* published an article entitled “Promise and Reality of Price Transparency” that described how “[m]any politicians and experts believe that price transparency will increase price shopping and reduce health care spending,” yet concluded that “[t]o date, price transparency has not achieved the promises of facilitating price shopping and decreasing spending.”⁷³ The article reasoned that price transparency tools may not have encouraged price shopping because many patients do not know about the available tools, the complexity of health care billing makes it difficult for patients to price shop, patients are not given standardized information that they can use to make price comparisons, most health plans do not have benefit designs that encourage price shopping, and patients do not want to disrupt their relationship with their provider.⁷⁴ Another article highlighted that there are many different purposes for price transparency, and determining the success of different price transparency efforts depends on the goal trying to be accomplished.⁷⁵ Similarly, some experts have questioned whether consumers are the best target of transparency efforts or, alternatively, if transparency targeted at other stakeholders, such as providers, would be more effective.⁷⁶

In addition to concerns about whether consumers are using price transparency tools and whether they decrease spending, some experts have cautioned that it is important to carefully structure price transparency initiatives to avoid unintentional consequences. For example, during a 2014 workshop at the Federal Trade Commission (FTC) examining health care competition and efforts to provide consumers, providers, payers, employers, and other stakeholders with meaningful price transparency, some of the panelists discussed how some forms of price transparency might have unintended consequences such as leading consumers to more expensive

⁷⁰ Foundation for Government Accountability, *Allies of Right to Shop: Paying Patients to Pick High-Value Healthcare* (Dec. 28, 2016), available at <https://thefga.org/research/allies-of-right-to-shop-2/>.

⁷¹ See, e.g., Foundation for Government Accountability, *How a Patient Experiences Right to Shop – Jenny’s Story* (Dec. 28, 2016), available at <https://thefga.org/research/how-a-patient-experiences-right-to-shop-2/>.

⁷² Ateev Mehrotra, MD, MPH, et al., *Defining Goals of Health Care Price Transparency: Not Just Shopping Around*, NEJM CATALYST (Jun. 26, 2018), available at <https://catalyst.nejm.org/health-care-price-transparency-goals/>.

⁷³ Ateev Mehrotra, M.D., M.P.H., Michael E. Chernew, Ph.D., and Anna D. Sinaiko, Ph.D., *Promise and Reality of Price Transparency*, THE NEW ENGLAND JOURNAL OF MEDICINE (Apr. 8, 2018).

⁷⁴ *Id.*

⁷⁵ Ateev Mehrotra, MD, MPH, et al., *Defining Goals of Health Care Price Transparency: Not Just Shopping Around*, NEJM CATALYST (Jun. 26, 2018), available at <https://catalyst.nejm.org/health-care-price-transparency-goals/>.

⁷⁶ See, e.g., *id.*

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providers.⁷⁷ Similarly, in a July 2015 blog post, the FTC cautioned that “transparency is not universally good,” and if it “goes too far, it can actually harm competition and consumers.”⁷⁸

III. ISSUES

The following issues may be examined at the hearing:

- Different state efforts to enhance price transparency and provide consumers with information about the cost of medical care and medical products;
- The purposes of different price transparency tools that states have adopted to provide consumers with information about the cost of medical care;
- How to most effectively provide consumers with meaningful price information that they can use to evaluate medical care;
- Concerns with some of the different price transparency efforts that have been pursued at the state level;
- Whether consumers have been using some of the various price transparency tools, and if not, the reasons that consumers have not been using them; and
- Whether there are other forms of transparency, such as transparency directed at providers rather than consumers, that should also be considered.

IV. STAFF CONTACTS

If you have any questions regarding the hearing, please contact Jen Barblan, Natalie Turner, or Lamar Echols of the Committee staff at (202) 225-2927.

⁷⁷ Federal Trade Commission, *Workshop Transcript: Examining Health Care Competition*, at 85-6 (Mar. 21, 2014), available at https://www.ftc.gov/system/files/documents/public_events/200361/transcriptmar21_0.pdf.

⁷⁸ Tara Isa Koslov and Elizabeth Jex, Office of Policy Planning, Federal Trade Commission, *Price transparency or TMI?* (Jul. 2, 2015), available at <https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi>.


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 Additional Hospital Information

January 2016 – December 2016

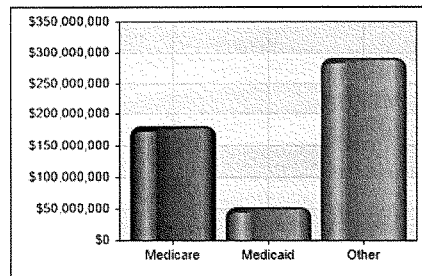
	Selected Hospital	All Hospitals in this County <input checked="" type="checkbox"/>	Hospitals with Similar Patient Care <input checked="" type="checkbox"/>	All Texas Hospitals
<input checked="" type="checkbox"/> Number of Discharges:	287	843	72,046	84,939
<input checked="" type="checkbox"/> Average Length-of-Stay:	3.5 Day(s)	3.1 Day(s)	2.8 Day(s)	2.8 Day(s)
<input checked="" type="checkbox"/> Average Charge:	\$28,364	\$22,800	\$24,131	\$23,786
<input checked="" type="checkbox"/> Average Charge Per Day:	\$8,104	\$7,355	\$8,618	\$8,495
<input checked="" type="checkbox"/> Median Charge:	\$26,201	\$21,935	\$21,892	\$21,836

NR = 1 - 4 Discharges (Not Reported)
☒ = Show hospitals in that group

☐ Notes About this Table
☐ Understanding Hospital Charge Information
☐ Why Charges May Differ Between Hospitals

**MEDICAL CENTER OF LEWISVILLE
 CHARGE AND PAYMENT INFORMATION
 MOST RECENT FISCAL YEAR - ALL SERVICES**

What is the selected hospital's "payer mix?" ☒
 A hospital's "payer mix" refers to the proportion of its total charges attributable to different types of insurance coverage.

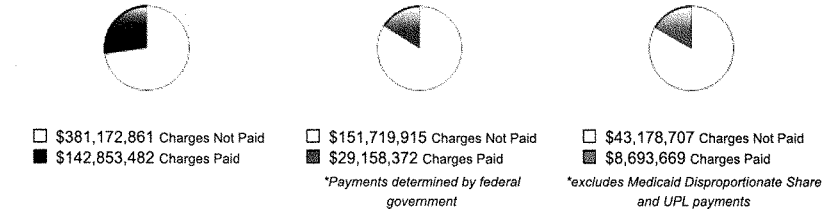


How much do government programs pay compared to private insurance? ☒
 In many cases, Medicare & Medicaid reimburse hospitals at rates that do not cover the costs they incur to provide

care. Payments from privately insured patients generally subsidize the shortfalls created by Medicare and Medicaid and therefore represent a "hidden tax" on individuals and families not covered by government programs.

The graphs below represent all services provided by the hospital; they are not specific to the selected service.

ALL PAYERS* This hospital collects an average of **27%** of its charges from all payers. **MEDICARE*** This hospital collects an average of **16%** of its charges from Medicare. **MEDICAID*** This hospital collects an average of **17%** of its charges from Medicaid.



The above information is for all services at the selected hospital. It is not specific to the service you selected or any other single service. Contact your insurer to determine the specific amount that will be paid under your policy for the selected service.

The table below details the health care charges that the hospital did not receive payment for because the patient qualified for free or reduced-charge care or because the patient failed to pay what was owed.

	Charges	Percent of Total Charges
Charity Care:	\$5,124,449	0.98%
Bad Debt:	\$23,950,252	4.57%
Total Uncompensated Care:	\$29,074,701	5.55%

The logo for HealthAffairs, featuring the word "HealthAffairs" in white text on a dark rectangular background.

HEALTH AFFAIRS BLOG

Building Something Worth Building For All Patients

Michael Burgess

MARCH 24, 2008 DOI: 10.1377/hblog20080324.000367

Editor's Note: Today, Rep. Michael Burgess (R-TX) kicks off a series of posts on Jon Gabel's article "Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns To Ambulatory Surgical Centers?," published March 18 on the Health Affairs Web site. The series will also feature posts from Jerry Cromwell and Chris Cassel.

To paraphrase the great American architect, Frank Lloyd Wright: no man should write about building who has not himself built something worth building. As a physician who helped build an ambulatory surgery center (ASC), I conform to Mr. Wright's formula and am glad to pen some thoughts about my personal experiences with the facility.

Let me begin by stipulating that I am neither a statistician, an economist, nor an academic. I have, however, practiced twenty-five years' worth of medicine. My experience is far-ranging: from a multispecialty practice, to a solo practice, and then in a single-specialty group. It was as a part of this single-specialty group I helped organize and start an ASC in my Texas hometown. And now, by virtue of the fact that I have been elected to Congress, one could argue that I've become an expert in almost anything. Therefore, I am grateful to have the opportunity to provide some alternative insights into the conclusions outlined in the piece by Jon Gabel and colleagues titled "Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns to Ambulatory Surgery Centers?"

While the overall piece is thoughtful, I take issue with some of the conclusions. First and foremost, it is unfair to assume that self-pay patients fall into one of two categories: those seeking cosmetic surgery or those who are wealthy. There are also those who lack health insurance.

Like other patients, the uninsured require and request surgery as well. In my own practice of obstetrics and gynecology, it was in dealing with patients who lacked health insurance where the payment disparity among different facilities became most apparent. Many times I encountered patients who desired operations, such as tubal ligation, but lacked health insurance. If they chose to pay for this operation, our local hospital would ask them to pay up front between \$8,000 and \$12,000. If, however, they were to make the same inquiry at an outpatient surgical

center, they would find the total facility fee to be in the range of \$1,000. My own modest fee for this procedure was in the neighborhood of \$400, which would be unchanged whether the surgery was performed in a hospital facility or an ASC.

In response to these facts, I would simply ask the rhetorical question: in which scenario was I more likely to be paid my fee? That in which the patient had paid \$1,000 for the facility or a figure about ten times as high? Invariably the patient's finances would be depleted by the hospital charge, and the physician's fee would often go unpaid.

Thus, if a patient with no insurance presented to my practice for an elective procedure, my likelihood of receiving compensation might, in fact, be increased if the patient were referred to an ASC, regardless of ownership.

Ownership encourages quality. Payment disparities are certainly a challenge. But, there are many other health care concerns today, including the issues of quality of care and payment for performance. One of the most controversial and complex subjects is physician-ownership of medical facilities, as evidenced by Gabel and colleagues' discussion. There is an old axiom that says no one ever checks the water in the battery of a rental car. There is a lot to be said for pride of ownership in any facility, including one's own office or one's ASC.

The relative efficiency of ASCs. Paperwork and policy are also problems when it comes to modern-day health care. In my own twenty-five years of clinical practice, I had multiple struggles

with hospital administration. Indeed, sometimes the conventional wisdom was that my local hospital behaved like an absentee landlord. I recall very vividly a five-year effort to get filtered drinking water for my hospitalized patients. It is not a battle I would like to relive at any point in the future.

Additionally, timing and schedules are critical parts of any medical practice. I was fortunate to have a robust roster of patients. So I began scheduling minor procedures on a day that I typically took out of the office. If I were to do four procedures at my local hospital, turnover time after each case would approach one hour. As a consequence, I could complete those four extra cases each week, but it would consume a large amount of time.

If, however, those four cases were performed in an ASC, turnover time was much shorter. It allowed me to place the patient safely in the recovery room, speak with her family, and dictate a procedure note before it was time to start the next case. This meant that those four cases could be accomplished by mid-morning and I could be off about other pursuits. Turnover time was reduced because the correct incentives were in place to make the facility run smoothly and safely.

The need for better data on physician owners of ASCs. While I disagree with several of Gabel and colleagues' assertions, I do concur with their statements about the difficulty in interpretation of data because of the lack of public information about physician owners of ambulatory surgery centers. In fact, without this relevant data, any conclusion drawn becomes suspect –

relying on broad generalities, or merely reinforcing preconceived notions. It is frequently hard to correct for observer bias.

Additionally, the statements on the difference between Medicaid and Blue Cross Blue Shield – in other words, those ranging from the lowest to the highest payer – were somewhat confusing. As a clinician, why would I want to invest more of my most valuable commodity (time) to treat a patient for which my reimbursement is lowest? In the interest of precious time, it seems that the incentive for treating the Medicaid patient would be tilted toward the ASCs, so that it could be done more efficiently. Whenever I am confronted with a set of medical choices, my first default question is always, “Is it safe?” Secondly, I might consider, “What is the least complicated option for me and my patient?” And third, “What are the clinical as well as the business outcomes?” Thus, if I found myself recommending a procedure for a patient, and it could be safely performed in a surgery center, regardless of the amount of available compensation, the ease of scheduling and the rapidity of performance would tend to influence me toward the outpatient facility.

There also might be a case to be made in terms of differentiation by specialties. Generalists such as gynecologists or general surgeons will typically have a broad mix of patients. Their diagnoses might reveal a different pattern than those among physicians who were more narrowly focused within a more well-defined specialty.

Differing attitudes toward the provision of health care. Finally, within the discussion section for this piece, perhaps the focus should not be on why the lowest reimbursement patients (Medicaid) were referred least often to an ASC. Instead, we should determine why Medicaid is the lowest payer. We should also explore what this says about those who want to expand the government's role in paying for health care.

The paper talks about 11 a.m. on a Sunday morning. The statement is made that this might be the most segregated hour of the week. I am not certain about the source of that data, but I do wonder if there is a mindset of a segment of the population who believe that they should pay nothing for medical care versus those who search for an affordable option when hospital costs have increased to a level would preclude their use.

The fact remains that both hospitals and ASCs are necessary for providing good, efficient, and cost-effective care in modern medicine. Physicians are more inherently aware of this fact than any other profession. Therefore, it is not surprising that they would want to provide these types of facilities or partner with their hospitals to provide these types of facilities, to provide the best possible care for their patients in an efficient and cost-effective manner. After all, it is patient care that really matters at the end of the day, and this begins and ends with doctors.

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July 17, 2018

The Honorable Buddy Carter
 United States House of Representatives
 432 Cannon House Office Building
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Dear Representative Carter:

The National Community Pharmacists Association wishes to thank the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations for conducting this hearing, "Examining State Efforts to Improve Transparency of Health Care Costs for Consumers." This is a vital hearing looking at health care price transparency that has emerged as a hot topic in state government and legislatures as a strategy for containing health costs for consumers and state governments. NCPA would like to share our experiences with states that have enacted legislation and initiated programs that aim to reduce costs and bring about increased transparency to the drug pricing system.

NCPA represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an \$80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis. Independent community pharmacies are also typically located in traditionally underserved rural and urban communities, providing critical access to residents of these communities.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state.

State efforts to increase PBM transparency in the Medicaid program

Spurred by patient concerns, policymakers in several states have examined PBM practices and contract management in their Medicaid managed care programs. Those policymakers have found Medicaid managed care organizations (MCOs) that fail to hold their PBMs accountable, narrow networks that limit patient access to trusted community pharmacists, PBMs that often pay themselves much more than they pay community pharmacies, and spread pricing models

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Representative Buddy Carter
July 17, 2018
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that disadvantage taxpayers. Having examined the role of PBMs, policymakers in some states are implementing reforms in their Medicaid managed care programs to correct these abuses.

For example, in the summer of 2017, West Virginia carved pharmacy benefits out of its Medicaid managed care program. The state's Department of Health and Human Resources made the move after an actuarial study showed that Medicaid could save \$30 million annually by administering the benefit directly, and that doing so would also put \$34 million back into local economies in the form of pharmacy reimbursements. Anecdotal reports from Medicaid officials indicate that the actual savings thus far are in line with the projections.

In Kentucky, the state spends approximately \$1.68 billion of taxpayer funds on the pharmacy benefit in the Medicaid managed care program. While testifying in front of legislative committees, the state Medicaid administrator could not explain where that money was going, other than it was going to MCOs. Data shows that as much as \$380 million could be going directly into the pockets of the PBMs. This lack of transparency and accountability drew the ire of legislators who soon thereafter enacted some of the strongest Medicaid transparency language in the country. Under the new law, Kentucky's Department for Medicaid Services has the authority to review and approve contracts between an MCO and its PBM, contracts between a PBM administering Medicaid drug benefits and a pharmacy, and PBM reimbursement rates. The law also requires PBMs to disclose the difference between the amount the pharmacy is reimbursed for filling a prescription and the amount the PBM charges the MCO for administering the claim.

Kentucky is not the only state to take action and increase transparency by examining PBMs' spread pricing models. Virginia and Georgia have also passed legislation requiring PBMs to disclose the difference between the amount the pharmacy is reimbursed for filling a prescription and the amount the PBM charges the MCO for administering the claim. Similarly, in Ohio and Pennsylvania, the state auditors have announced plans to review PBM practices in those states' Medicaid managed care programs and investigate potential wrongdoing after realizing that community pharmacies' reimbursements have been decreasing, but overall state spending on prescription drugs continues to increase.

Conclusion

Members of this subcommittee should be just as concerned as state policymakers have been in realizing how harmful a lack of transparency is when it comes to PBMs' use of public tax dollars. MCOs have not been holding PBMs accountable, and states are beginning to take control. Those states have learned that constant vigilance and increased transparency is necessary to keep PBMs honest and ensure public funds are spent properly. These measures not only protect taxpayers' wallets, but they ensure that Medicaid beneficiaries can continue accessing the services of trusted community pharmacists. The success of these and similar initiatives have

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been noticed by states and organizations across the country, including the National Council of Insurance Legislators, which is currently developing model PBM transparency legislation. While examining efforts to improve transparency of health care costs of consumers, the committee should pay close attention to the success that states have had by increasing PBM transparency.

Sincerely,

A handwritten signature in black ink, appearing to read "Karry K. La Violette", followed by a horizontal line.

Karry K. La Violette
Senior Vice President
Government Affairs and Director of Advocacy Center